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National Hospital Rate-Setting Study, Vol. V

Case Study of Prospective Reimbursement in Minnesota

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Health Care Financing Grants and Contracts Report

Case Study of Prospective Reimbursement in Minnesota

This report was made pursuant to contract No. 500-78-0036 between Health Care Financing Administration and Abt Associates Incorporated, Cambridge, Massachusetts.

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MINNESOTA

A voluntary prospective reimbursement program began in Minnesota in 1974 under the administration of the Minnesota Hospital Association (MHA). Legislation passed in 1976 required all hospitals to submit proposed budgets for review, but compliance with the findings of the review process is still voluntary. MHA still operates the program for all but one hospital, under power delegated to it by the Department of Health (MDH). One small hospital in the state submits its budget for annual review by staff of the Department of Health. MHA staff examine budget proposals for each of 15 functional cost categories (e.g., salaries, medical supplies, interest expense) for changes which may be out of line with previous performance or expected inflation. Official review of budgets and the preparation of recommendations are carried out by six external Rate Review Panels. Each panel consists of three hospital representatives, two third-party representatives and two consumer representatives.

The analytic procedures used to evaluate budget proposals in Minnesota are neither elaborate nor stringent. The overall criterion is reasonableness in relation to financial requirements as defined by the American Hospital Association (and modified by MDH). Using standard worksheets, MHA staff analyze trends over a three-year period (rate year, base year and prior year) in cost, personnel, and other items. For major statistical indicators, hospitals are compared to others in their peer group to identify performance which deviates significantly from group averages. These analyses are used to identify specific items for discussion before Rate Review Panels. The review process in Minnesota focuses primarily on hospital budgets, but the findings ultimately handed down are approved percentage increases in hospital rates (e.g., cost and revenue per diem) for the upcoming year.

Although compliance with the recommendations of the Rate Review Panels is voluntary, hospitals are required to indicate whether or not they will comply with the recommendations. To date, only one hospital formally indicated that it would not abide by its approved budget. Several large hospitals have indicated that they would not comply with specific special recommendations (e.g., to reduce nursing staff). Blue Cross has begun to require compliance with panel recommendations as a condition for receipt of a Blue Cross contract but has not yet begun to monitor compliance.

ACKNOWLEDGMENTS

The authors would like to acknowledge that information for this case study was provided through personal and telephone interviews, correspondence, and secondary data supplied by many people. A list of these people is included in Appendix B of this report.

The authors would like to especially acknowledge the following people for the generous amount of time and effort they contributed to our knowledge.

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Minnesota Rate Review Program
Minnesota Hospital Association

Dr. Gary Appel
Director of Health Economics
Minnesota Hospital Association

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Also, the authors express sincere appreciation to HCFA staff for their technical assistance, especially to prior project officers, Fred Hellinger, Ruth Lis, Arne Anderson, and Bruce Steinhardt.

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FOREWORD

The following case study report of prospective reimbursement in Minnesota has been written as part of the National Hospital Rate-Setting Study. This study is being conducted for the Office of Research, Demonstrations, and Statistics of the Health Care Financing Administration, U.S. Department of Health, Education, and Welfare, by Abt Associates Inc., Policy Analysis, Inc., and Health Economics Research, Inc.* The overall goal of the three-year study is to determine the impact of rate setting on hospital costs, quality of hospital care, and access to health care by the elderly and the economically disadvantaged. In addition, the study will examine the impact of prospective reimbursement on other areas of hospital performance, including revenues, volume and composition of services, productivity, wages, case mix, and administrative behavior. Because the effects of prospective reimbursement may be felt beyond the hospital sector, the study will also examine impacts on the costs and utilization of the health care system as a whole.

This volume is one of nine case study reports (Arizona, Connecticut, Maryland, Massachusetts, Minnesota, New Jersey, New York, Washington, and Western Pennsylvania). Each report examines in detail the adoption, implementation, review processes and legal challenges of each prospective reimbursement system. In addition, the reports examine linkages and interactions that take place between rate-setting agencies and other organizations such as planning groups, hospital associations, third party payors, and unions. Each case study also presents a preliminary analysis of the potential rigor and equity of the prospective reimbursement system. (A separate report, A Comparative Analysis of Nine Prospective Reimbursement Programs, analyzes all nine programs simultaneously along these factors.) The case study reports will be most useful to those interested in a detailed description of the prospective reimbursement programs in the nine states under study.

The preliminary analyses of rigor and equity in the case studies are interim in nature. Data collection on hospital performance is still ongoing and will yield important information about the effectiveness of administrative structures and procedures in containing costs and delivering quality service. Final results of the study are expected in 1982.

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Deputy Project Director &
Director of Case Studies
National Hospital
Rate-Setting Study

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*Arthur D. Little, Inc. and Arthur Andersen & Co. are also participating in the National Hospital Rate-Setting Study but were not involved in the case studies.

INTRODUCTION

The System

The Minnesota Hospital Administration Act of 1976, enacted in May 1976, gave statutory authority to the Department of Health to maintain a hospital rate review system for the purpose of prospectively reviewing and commenting on hospital rate increases. Hospital reporting is mandatory but compliance with system recommendations is voluntary.

The real genesis of the current mandatory program was a voluntary program begun in late 1974 by the Minnesota Hospital Association (MHA) and continued by them until the legislated program became effective on June 22, 1977. Indeed, except for the fact that MHA reports to the Minnesota Department of Health (MDH) and that all hospitals are required to participate, the existing review program is not substantially changed from the earlier voluntary one. Actual rate review is still conducted by MHA, under delegation from MDH, using the same organization and review panels and much the same review process and definition of financial requirements.

The Rate Review System is not strictly a rate review program inasmuch as the rates themselves are not what is reviewed; it is perhaps more correctly called a budget review program. The subsequent year's budget is the focus of the review, and rates are set consistent with an approved budget. The definition of financial requirements, i.e., the specification of allowable costs, is somewhat generous, allowing for substantial price-level adjustment on depreciation.

Each hospital must submit its budget request to either the state or an approved voluntary rate review organization no more than sixty days prior to the end of its fiscal year, but at least sixty days prior to increasing its rates. From the beginning, the Minnesota Hospital Association (MHA) has been approved by the state as an alternative rate review organization. All but one hospital have opted to have their rates reviewed by the Hospital Association. For all practical purposes, then, the actual review of hospital rates is being conducted under the auspices of MHA. However, MHA personnel are not ultimately the ones responsible for reviewing and commenting on hospital rate requests. They receive and process the requisite budgetary and financial reports, prepare summary exhibits, and indicate areas of concern, but the actual review is done by six external Rate Review Panels, each of which includes three hospital representatives, two third-party representatives and two consumer representatives. The panels are also assisted by a technical advisory group, the Rate Review Subcommittee of MHA's Finance Committee. Apart from the rules defining financial requirements, the panels have no formal direction or guidelines for conducting the review. Although almost all hospitals notify MHA of their intent to comply with rate review recommendations, there has not to date been any systematic attempt to monitor actual compliance with the rates set.

Many of those interviewed noted that Minnesota is unique in the health care sphere, and that, in general, Minnesota is one of the more progressive states. Minnesota is, after all, the state of the Democratic Farm-Labor (DFL) party, Hubert Humphrey and Walter Mondale, and it spends a surprisingly large share of its resources on human services.[1] On the whole, the state and its health care system seem to be characterized by a more cooperative, less adversarial approach to problem solving than are most other states. That is, they demonstrate a greater willingness to compromise and participate in solving the problem, rather than having some less satisfactory solution imposed by external authority (e.g., the legislature).

Some examples of Minnesota's progressiveness and cooperation in the field of health care include the following: (1) The Minnesota hospital-initiated Joint Commission on the Development of Areawide Planning was a forerunner of today's state health planning system. (2) The Minneapolis/St. Paul metropolitan professional services review organization (PSRO)--the Foundation for Health Care Evaluation--appears to be unusually successful in terms of reducing hospital patient days. (3) Two metropolitan area hospital trustee groups were organized in 1977 to assist the Metropolitan Health Board (the health systems agency) in planning bed reductions. Both groups supported a finding of excess capacity. In addition, the West Metro Trustee Group recommended closing services in some hospitals and alluded to the possibility of closing some hospitals altogether. (4) As recently as September 1977, MHA testified before the Joint Senate-House Subcommittee on Health Cost, offering their best guess of the level of inefficiency that could be corrected. They said that Rate Review could trim $45 million or 4.5 percent of the annual hospital expenditure over the next three years and not affect the level or quality of services provided. (5) Minnesota is also a center of health maintenance organization (HMO) activity.

Comparative Trends in Minnesota Hospitals

This section considers the trends in certain Minnesota hospital industry indicators in relation to national trends. Changes over time in Minnesota are compared with those for the nation for the following variables: total number of beds, total patient days, occupancy, length of stay, expense per patient day, revenue per patient day, assets per bed, and expense per capita (see Figures 1 and 2). To understand and interpret trends, however, it is important to realize that Minnesota was among the few states to achieve the Hill-Burton goal of five beds per 1,000 population and is therefore perceived to have excess capacity by current standards. In addition, and perhaps as a consequence of excess capacity, the hospitalization rate and average length of stay in Minnesota have been substantially higher than the national averages.

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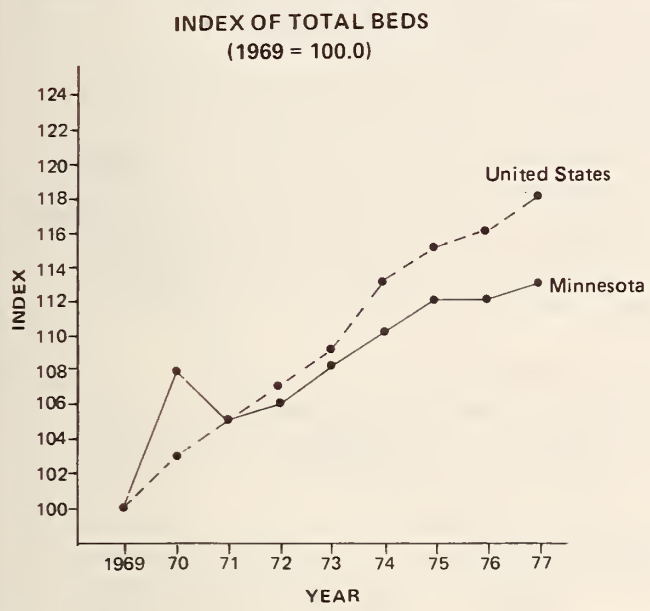
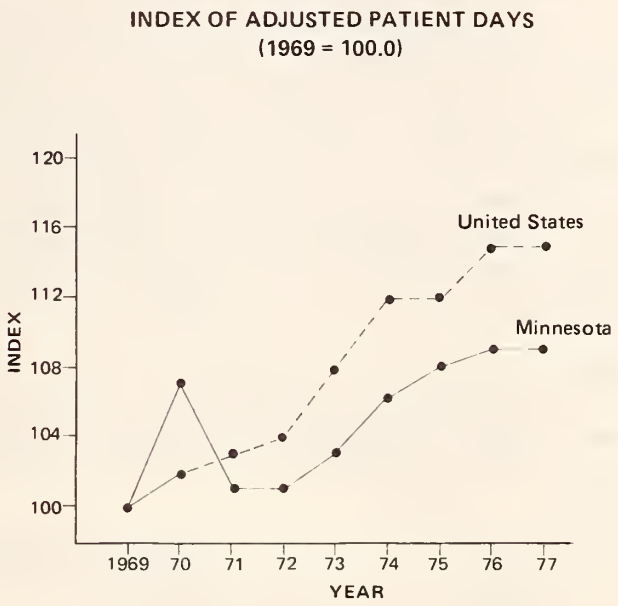
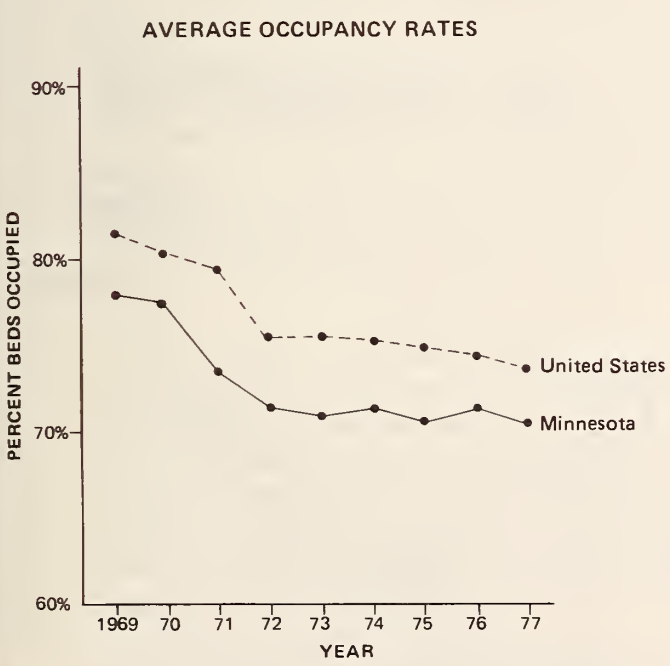
[1]The state's political climate now appears to be changing. The newly elected governor is Republican, and the formerly Democratic Farm-Labor (DFL)-dominated House is now evenly split.

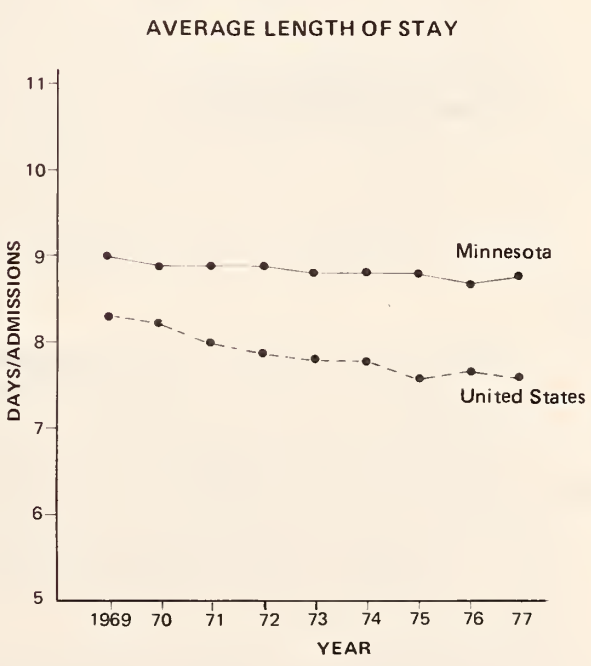
Figure 1

COMPARISON OF HOSPITAL INDICATORS:
Capacity, Volume of Service and Utilization
for Community Hospitals, 1969-1977
MINNESOTA vs. U.S.



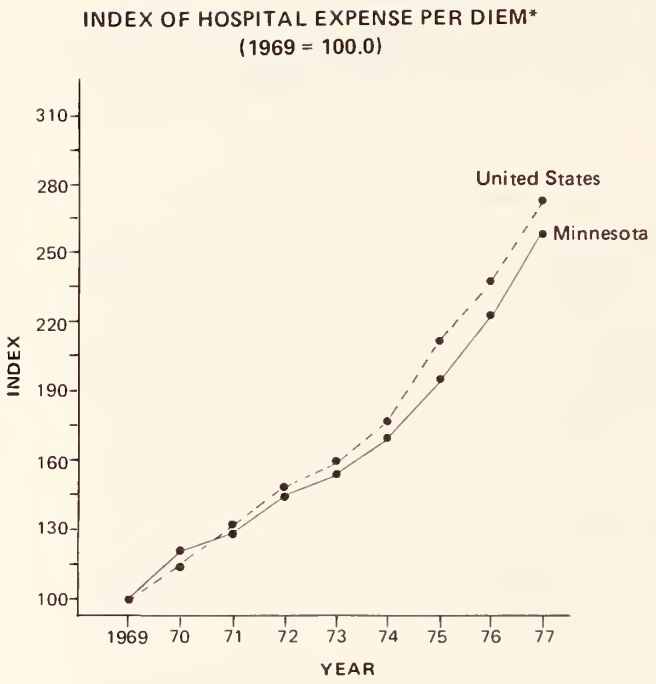


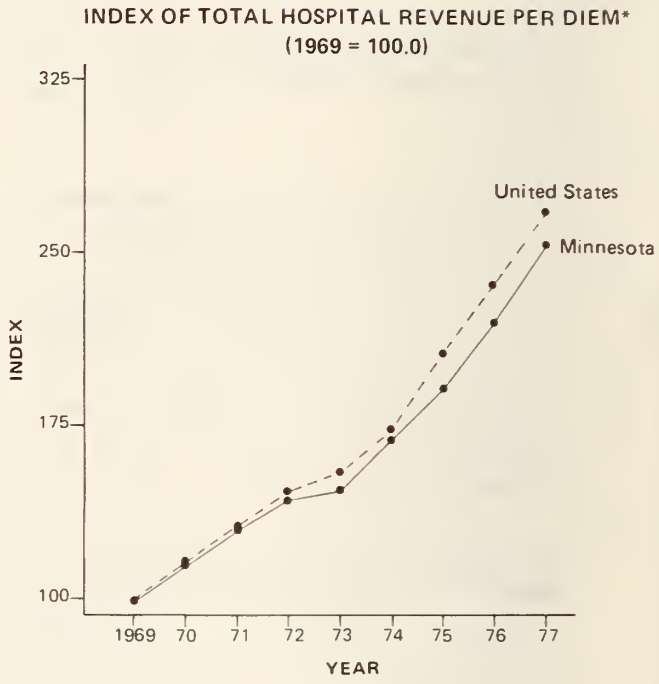


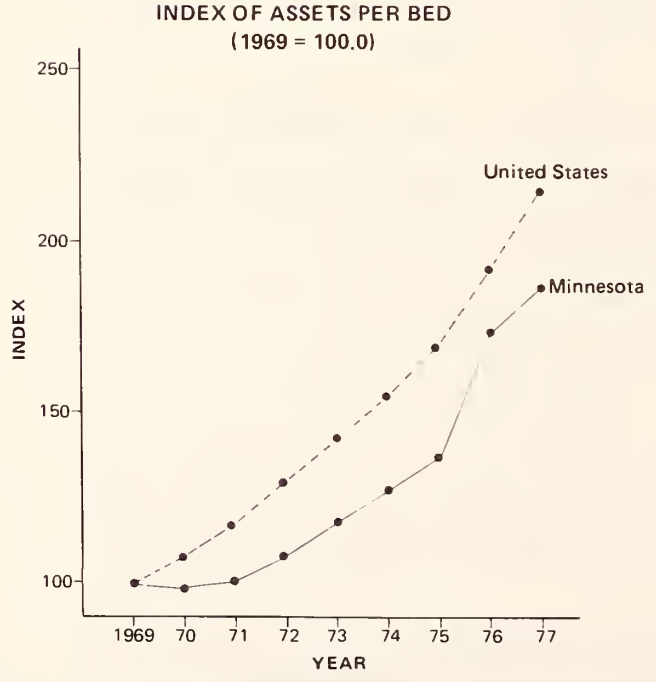


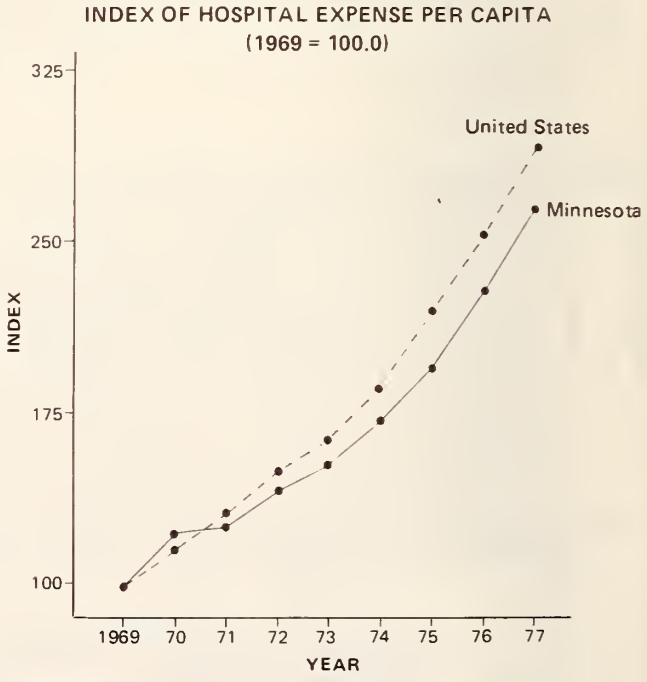
Sources: U.S. Bureau of the Census
American Hospital Association, *Hospital Statistics*

Figure 2
COMPARISON OF HOSPITAL INDICATORS:
Expense, Total Revenue and Assets
for Community Hospitals, 1969-1977
MINNESOTA vs. U.S.









*Per adjusted patient day.

Sources: U.S. Bureau of the Census
American Hospital Association, *Hospital Statistics*

Although the index of total beds has risen less quickly in Minnesota than throughout the entire country, this no doubt reflects the initial excess capacity situation.[1] The index of adjusted patient days, reflecting hospital volume, has increased less rapidly. Thus, the Minnesota hospitalization rate is apparently converging toward the national average.

The financial comparisons are deceiving because Minnesota's costs and revenue were high initially. In addition, the AHA hospital statistics from which these figures were developed relate to the entire institution and not only the hospital part in those hospitals offering SNF services. Since more than eleven percent of AHA-reported beds in Minnesota are actually convalescent and nursing care beds, compared to only three percent nationally, both the per diem amounts and their rates of change understate the more appropriate comparative statistics. This may be another reason why Minnesota's average length of stay appears greater than the national average.

Finally, the lower rate of increase in assets per bed is likely due to the excess capacity problem. In particular, there has not been much recent hospital construction in Minnesota and capital assets have on average been capitalized at lower historic prices.

ORIGINS AND LEGAL FOUNDATIONS OF THE MINNESOTA HOSPITAL RATE REVIEW SYSTEM

The Minnesota Hospital Administration Act of 1976 requires hospitals to report all rate increases to the Department of Health (MDH) sixty days prior to implementation and gives statutory authority to MDH to collect and analyze data on hospital costs, rates and financial condition; publish and disseminate information relating to hospital costs; and review and comment on projected hospital revenue and expenses. Because the real genesis of the current mandatory program was a voluntary program begun in late 1974 by the Minnesota Hospital Association (MHA), it is important to begin with a discussion of the earlier MHA voluntary effort.

In 1972, some MHA member hospitals began reporting to MHA very limited financial and statistical information, about twenty data items, on forms developed by the Economic Stabilization Program (ESP). MHA began reviewing rate increases from this information. However, neither MHA nor the review panels, composed entirely of hospital personnel, were satisfied with this review program; the forms did not elicit sufficient information, the program was not well understood, and only ten to fifteen percent of the state's hospitals participated.

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[1] The abrupt changes in the index of total beds and the index of adjusted patient days between 1969 and 1971 are thought to be due to reporting errors on the AHA survey.

In 1974, MHA's Finance Committee and Board decided that it was important to overhaul this limited rate review system. The Chairman of the Finance Committee at that time noted that the regulatory climate had changed and that "it was either us or the government." Other MHA representatives talked with similar candor about the impetus for a more serious voluntary rate review effort. As one hospital administrator and architect of the voluntary program indicated, the legislature was extremely concerned about rising health care costs. Either the Minnesota hospital industry would have to undertake some greater effort at cost containment or the state would take a public utility view of hospitals and begin regulating rates, as was happening in other states, such as Washington.

Nevertheless, it was also said that enlightened self-interest was not the sole motivation for MHA's voluntary program; the program was also a public-spirited effort on MHA's part to sensitize member hospitals to the public's concern about rising costs and to encourage better financial planning.[1]

The following were the stated objectives of the Minnesota Hospital Association:

- to contain the rate of increase in the cost of health care in member institutions;

- to provide these institutions with sufficient revenue to meet the financial obligations that result from the provision of care consistent with community need and in compliance with the health planning requirements subject to the review and approval of Rate Review Panels; and

- to have all third-party payors accept this program as the basis for determining rates of hospital payment in lieu of present cost-based reimbursement.

In designing the program, members of MHA's Finance Committee met once or twice a week for nearly a year. They were assisted by representatives of the Hospital Financial Management Association (HFMA)--hospital financial officers--and initially by representatives from two CPA firms as well as by Blue Cross/Blue Shield. The Chairman of the Finance Committee made the rounds and spoke at MHA regional meetings to persuade MHA members to participate in the voluntary Rate Review Program. In total, two man-years were estimated as a ball-park figure for the amount of unpaid time that went into developing the voluntary system. In addition, two CPA firms

[1]It was also said that some rural hospitals were having working capital problems.

(Touche Ross & Co. and Robert J. Englehardt & Co.) were each paid about $5,000. No appreciable MHA staff time is said to have been involved in these early stages of program development.

The voluntary rate review program was based on the definition of financial requirements set forth in the Statement on the Financial Requirements of Health Care Institutions and Services as approved by the American Hospital Association on February 12, 1969. A key difference between this and more conventional definitions of financial requirements was that it included price-level increment on depreciation; it permitted the hospital to depreciate all assets as if they had been purchased at current price levels. This provision continues in the present system, except that interest on the depreciation fund is now offset against the price-level adjustment. As will be seen, other features of the voluntary program also remain largely unchanged in the present program.

Although all MHA members were "expected to participate" in the voluntary rate review program, only about one-third of Minnesota hospitals--60 of 180--actually did so. The participating hospitals were predominantly the larger, more urban hospitals, which account for almost eighty-five percent of Minnesota hospital costs.

In 1974, some legislators and their staff also began thinking about rate setting as a mechanism for cost control. In fact, the Senate Majority Research Group drafted a bill to establish a rate-setting system similar to the one in Maryland. However, because of the political atmosphere at the time, the bill was never introduced.

Also in 1974, a joint House-Senate committee, organized to look at hospital costs, requested hospital cost data from MHA, which declined to provide it. This incident naturally led to an interest in acquiring such information by legislative means. A Democratic Senator subsequently sponsored a bill to require disclosure of financial information by hospitals and to give the state the authority to review rates. In committee, rate control or rate setting was never discussed; debate tended to focus on less global issues, such as whether or not HMO discounts or charity care should be allowed in the financial requirements. The bill was eventually approved in the Senate and sent to the House. In the House it was attached to another bill having two major articles: (1) a catastrophic health insurance plan drafted by the Governor and modeled after the one in Rhode Island and (2) a requirement that all insurors and employers offering any health insurance plan also make available a health insurance plan with a minimum level of benefits.

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[1]The Minnesota Public Interest Research Group is a consumer protection-oriented group at the University of Minnesota.

Support for the bill came primarily from the Minnesota Public Interest Research Group and a senior citizens' group, the Senior Federation.[1] Initially, the Hospital Association and the Minnesota Medical Society opposed the bill. However, MHA supported the final version when it emerged from committee with an option for hospitals to be reviewed by a voluntary, nonprofit rate review program instead of MDH. This provision gave MHA the opportunity to continue its responsibility for hospital rate review. The Minnesota Association of Health Care Facilities, the statewide organization of nursing homes, also opposed the bill. Surprisingly, the insurance industry did not speak out on the issue.

The rate review legislation is known as the Minnesota Hospital Administration Act of 1976.[2] Except for the section authorizing voluntary peer review of hospital costs, the Act represents more of a requirement for the reporting of hospital financial information than a mandate for rate review. The following constitutes the sole authority for rate review:

> The board may initiate reviews or investigations as necessary to assure all purchasers of hospital health care services that the total costs of a hospital are reasonably related to the total services offered, that the hospital's aggregate revenues as expressed by rates are reasonably related to the hospital's aggregate costs, and that rates are set equitably. . . . In order to properly discharge these obligations, the board may review projected annual revenues and expenses of hospitals and comment on them.

The Act is not even a clear mandate for comprehensive rate review. It merely allows for the possibility of such review by inclusion of the words, "review" and "comment."

A legislative assistant to the House Health and Welfare Committee reported that the legislature is very satisfied with the existing statute and does not have any plans to modify it. He felt that any problems could and should be worked out administratively, pointing out that, with the recent election of a Republican governor and an even split in the formerly DFL-dominated House, there would be no chance in the near future of passing legislation to put more rigor into the system.

The rules or regulations were written between July and mid-October in 1976. Although hospital administrators, doctors, ccnsumer groups, MHA and

---

[1]The Minnesota Public Interest Research Group is a consumer protection-orientd group at the University of Minnesota.

[2]The Act consists of Minnesota Statutes 144.695 through 144.703.

MDH were consulted, the proposed rules were actually drafted by a consultant to the Department of Health, the former legislative assistant to the House Health and Welfare Committee. The rules were based in part on those of Maryland, Washington, and Massachusetts. A hearing was conducted on the proposed rules in January 1977, and the rules were promulgated with no major changes on June 20, 1977 as "Rules Relating to the Minnesota Hospital Rate Review System."

Except for less generous treatment of unrestricted funds and the offset to price-level depreciation, the rules define financial requirements consistent with the definition recommended by the American Hospital Association and adopted by MHA in its Voluntary Rate Review Program, including a proviso that the rates charged to patients or their insurors by a hospital must be adequate to maintain the solvency of the hospital. However, apart from specifying hospital reporting requirements, the rules say little about the process of rate review itself. The rules state only the following with respect to the review process:

> The system shall comment upon interim increase reports and rate revenue and expense reports to the hospital, the Commissioner of Health and the public prior to the implementation of proposed budgets or rates. The comment shall state that a hospital's existing and proposed rates are reasonable or are in question.
>
> 1. Bases which may be used to comment that a hospital's existing rates are reasonable include:
>
>   a. Rates are similar to the average of the aggregate rates then in effect for other hospitals in a peer group;
>
>   b. Prospective aggregate rates represent a minimal increase which is consistent with the principles of the bases for judging established by 7 MCAR S. 1.487A;
>
>   c. Aggregate rates have been demonstrated by the hospital to be necessary and consistent with the principles of the bases for judging established by 7 MCAR S. 1.487A;
>
> 2. Bases which may be used to comment that hospital's existing and prospective rates are in question include:

a. Rates deviate from the average of the rates then in effect for other hospitals in a peer group;

b. Rates have not been demonstrated by the hospital to be necessary and consistent with the bases for judging established by 7 MCAR S. 1.487A (p. 31).

This section has been subsequently modified to include cost as a criterion for review and comment. The rules also indicate an occupancy or excess bed "penalty" and provide for volume adjustment. These provisions will be implemented in review of the 1980 budgets. The specific procedures originally indicated for volume adjustment, using fixed/variable cost ratios, were deleted in revision of the rules. A more general statement indicating that volume and other considerations (e.g., productivity) are to be taken into account in reviewing compliance with rate review recommendations has been substituted. The only authority for rate restriction is a requirement that hospitals file required reports at least sixty days prior to changing their rates. The rules also stipulate the process for approving delegation of rate review to a voluntary, nonprofit organization. Although the rules incorporate authority for special investigation of hospital rates, the rate review system to date has limited itself to annual budget review. Other provisions of the rules will be noted in the discussion of the review process itself.

The rules have been revised only once since their original adoption. The State of Minnesota has an arduous Administrative Procedures Act requiring: (1) formal consultation; (2) publication of proposed rule changes; (3) a formal hearing; (4) a period during which the record is open for additional comment; (5) a hearing examiner's report; and (6) approval by the Commissioner of Health. The notice of intent to solicit opinions was published February 27, 1978; the proposed rule changes were filed on August 24; a hearing was conducted on September 25; and rule changes were finally promulgated on March 5, 1979. Eleven written comments were received prior to publication of the proposed rule changes, and two prehearing and five posthearing written comments were received prior to closing the record. Thirty-five persons attended the hearing and ten appeared as witnesses.

The rule changes were adopted basically as proposed by MDH and developed in consultation with insurors, hospitals, and HSAs. Many of the changes merely sought to clarify reporting requirements and definitions that had presented problems in the first year. The following changes were more significant:

(1) Hospitals maintaining their accounts in different forms than that recommended were authorized to submit their financial reports in that format if they also provided

a detailed reconciliation of the differences. MHA objected that the detailed reconciliation requirement was tantamount to imposition of uniform reporting and accounting. MDH attested that it was not.

(2) Smaller hospitals were relieved of certain burdensome and less appropriate reporting requirements.

(3) Hospitals were given the option of financing additional free care from depreciation. One-half of the Hill-Burton liability had already been allowed in the rates. Five witnesses spoke in opposition, arguing that this provision could result in depletion of a hospital's net worth.

(4) The sections indicating fixed/variable cost ratios for volume adjustment were deleted and replaced with a more general directive that:

(a) Hospitals should not benefit from unanticipated gains resulting from underestimates of projected reasonable revenues, and/or volume, and/or overestimates of the costs of services delivered. However, hospitals should benefit from productivity increases that reduce the reasonable cost of delivered and/or offered services.

(b) Hospitals should not be penalized for incurring unanticipated losses resulting from overestimates of reasonable volume, and/or revenue, and/or underestimates of the reasonable costs of services delivered. However, hospitals should not carry forward losses resulting from conditions that should have been averted and/or from decreases in productivity.

(5) Rate review was authorized to allow for review and comment on costs, including cross-subsidization, as well as the rates themselves.

(6) Budget-year inflation guidelines were directly tied to the allowable increase limit issued by the Commissioner of Health.

No additional rule changes have been formally proposed to date.

CONTENT AND PROCESS

Organization of the Minnesota Hospital Rate Review System

The Minnesota Hospital Administration Act of 1976 requires financial reporting by all hospitals in the state, provides authority for rate review, and gives the Minnesota Department of Health (MDH) overall responsibility for managing the program. However, the statute also permits delegation of rate review and data collection responsibility to an approved, voluntary, nonprofit organization that has rate review as one of its "primary functions" and whose reporting and review procedures have been found to be "substantially equivalent" to those adopted by MDH.

As has been mentioned, the Minnesota Hospital Association (MHA) has been approved by the state from the beginning as a rate review organization. Thus, a hospital can choose to be reviewed by either the Hospital Association or the state. All but one hospital have opted to have their rates reviewed by the Hospital Association,[1] so the actual review of hospital rates is essentially being conducted under the auspices of MHA. The half-dozen or so rate review staff, including the program director, are in fact full-time employees of MHA. However, these MHA personnel are not ultimately the ones responsible for reviewing and commenting on hospital rate requests. In principle, this is done by six external rate review panels, each of which includes three hospital representatives, two third-party payor representatives and two consumer representatives.[2] Each panel selects its own chairman, who may not be a hospital representative. Some committees elect permanent chairmen whereas others select a different chairman for each review meeting. The chairman does not vote except to break a tie.

The Rate Review Panel members are appointed by MHA for one-year terms, although most panel members have been with the program since January 1976. Consumer participation was originally solicited via an open letter to major corporations in the Minneapolis-St. Paul area. Among companies participating and sending representatives are the Dayton-Hudson Corporation

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[1] Swift County Benson Hospital, a small, rural hospital, is being reviewed by the Department. The hospitals administered by the Department of Public Welfare do not participate in the system. A hospital must remain with its choice of approved voluntary review organization for a minimum of three years.

[2] Occasionally, a third-party representative substitutes for a consumer and vice versa. Five panel members are needed for a quorum, and the hospital representatives may not be in the majority.

(retail), Northern State Power, Northwest Bell, and Control Data.[1] Corporate representatives typically come from the company's personnel department and thus have an interest in containing the costs of health insurance and consequently the costs of health care provided as a fringe benefit to their employees. The largest number of third-party representatives, between five and seven, come from Blue Cross/Blue Shield of Minnesota; the others come from HMOs or independent insurors, including the HIAA representative. Third-party and hospital participation was solicited more informally.

Each panel meets once a month to review hospitals' budgets. The nonhospital representatives, i.e. the third-party payor and consumer representatives, are entitled to a $110 honorarium for days spent on review. There is no additional payment for time spent in advance preparation. Some panel members simply refund the payment to their employer and receive their usual salary in lieu of the honorarium. Although this is done at Blue Cross/Blue Shield, the Blue Cross/Blue Shield Director of Provider Reimbursement reported that the honoraria did not fully repay the cost of participation. Other panel members, especially the consumer representatives, take vacation on the day of review and retain the honoraria themselves. The hospital representatives apparently receive their usual salary on review days. Hospitals are thought to have intrinsic incentive to participate inasmuch as they are shaping policy that affects the industry. Moreover, the individual hospital participants gain a better understanding of the review process than do their peers in nonparticipating hospitals and may thus gain an advantage in presenting their own hospitals for review.

In theory, the primary function of MHA Rate Review staff is to assist the Rate Review Panels. However, as will be described, the staff exercises considerable discretion in determining the intensity and locus of review. The MHA Director of Health Economics, with a Ph.D. in economics, is also Director of Rate Review and spends 25 to 30 percent of his time on rate review matters.[2] The full-time Program Manager has an MBA and had initially joined the staff as a financial analyst. A senior analyst position has been vacant since June 1978. In addition, Rate Review staff include two financial analysts and two junior financial analysts, one staff assistant, and clerical support. The financial analysts typically have MBA degrees in finance, economics or accounting, and junior financial analysts usually have B.A. degrees in the same disciplines. The turnover of financial analysts has been quite high because salaries are not competitive and staff have better opportunities elsewhere once they have gained a year or two of experience. The hospitals tend to hire such persons.

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[1] 3M was determined ineligible for participation because of potential conflict of interest since it manufactures products for hospital use.

[2] The MHA Director of Rate Review has recently resigned to take another job; the Program Manager has assumed that responsibility for the time being.

The Rate Review Panels are also assisted by a technical advisory group, the Rate Review Advisory Subcommittee of MHA's Finance Committee. This group consists entirely of hospital financial and administrative personnel, except for one nonvoting CPA member. The group is responsible for answering technical questions referred to it by the Rate Review Panels--e.g., What is an appropriate inflation factor for natural expense inflation--and for helping to resolve inconsistencies that result when different panels interpret the rules differently. Informally, the Rate Review Advisory Subcommittee reports to the staff, and the staff reports its determinations to the Rate Review Panels. Formally, this technical advisory group reports to MHA's Finance Committee and must have its major decisions approved by them and by MHA's Board of Directors. The Finance Committee also has overall responsibility for establishing MHA policy in light of their participation in the system as a voluntary rate review organization.

Although MHA is reviewing virtually all hospitals, MDH considers that it still has a variety of organizational functions. First, MDH is responsible for the annual review of MHA's or anyone else's application as a nonprofit rate review organization. Second, MDH is responsible for monitoring MHA compliance with the statute and the rules. Third, MDH is responsible for program development inasmuch as the reports and procedures of a voluntary review organization must be "substantially equivalent to those established by the system." That is, MDH has the authority and responsibility to define the process by which all hospitals are reviewed. Fourth, MDH has the statutory authority and responsibility for changing the rules, subject, of course, to due process requirements. In addition, MDH has statutory authority to collect data and undertake studies that will contribute to policy formulation, and to disseminate information on hospital costs and charges. Finally, MDH believes that it must maintain the "stand-by" capability to take over the actual rate review process in the event that MHA or some other nonprofit rate review organization is not approved by them for that purpose.

The former Director of MHA's earlier voluntary rate review program is Director of Hospital Rate Review for the state. He has an MBA and doctoral training in finance and economics. The Director is assisted by a Program Analyst with MPH and master's level training in economics.

The organizational relationship between MDH and MHA has not been close. State monitoring of MHA has been laissez-faire, and consequently, MHA has enjoyed great independence. Health Department staff rarely attended Rate Review Panel meetings during 1977 and 1978. MDH believes that it should allow each review to occur in a relatively free environment, without undue MDH influence or interference. MDH merely reviews the outcome of each review from the official record submitted to it by MHA. Thus, questions of rule interpretation can emerge in panel review and be referred to MHA's Advisory Subcommittee for decision without any consulta-

tion by the state. MHA does, however, seek confirmation of significant policy decisions with the state. To date, there have been no major policy confrontations between the state and MHA. However, MHA did for a period of time defy MDH's interpretation of the rules relating to capital depreciation in the budget year.

In other instances, MDH has been less forceful in imposing its position on MHA, and MHA has at least temporarily prevailed. For example, MHA has declined to use the set of forms developed by the Department and the model developed by the Department for projecting inflation in the budget year, and has declined to use and share a common data base on state computers. Furthermore, the exhibits being used by MHA for review do not conform to the recommendations of the Department, but MHA has in each case given some rationale for not acceding to MDH's recommendation. For instance, the Department's forms were judged unusable in light of a six-month trial implementation by the Hospital Association; according to MHA, MDH's inflation-predicting model is based upon nationwide data that do not generalize to the state, and the state's computer system is too expensive.

While MHA has been specifically asked to collaborate in all of the Department's developmental projects, MHA has rarely participated, maintaining that it has not had sufficient resources to both conduct the review program and give attention to developmental considerations. Nevertheless, in response to the perceived shortcomings of MDH developmental activities, MHA has independently revised the form set, modified its data processing activities, and implemented a delphi panel type methodology for projecting inflation.[1]

MDH is apparently tightening its control. MHA's 1978 application for recertification as a voluntary rate review organization underwent extensive and protracted review by MDH for seven and one-half months. The following were negotiated as conditions for MHA's recertification:

1. The rate revenue and expense reports and instructions shall be determined to be substantially equivalent to those established by MDH.

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[1]The Department had at one point invited MHA to participate in a study to establish criteria for cost-justified discounts. MHA declined to participate, and consequently, MDH decided not to pursue the study. MDH has subsequently resisted pressure from Blue Cross/Blue Shield and others to conduct such a study. MHA has now agreed to conduct such a study and has asked the Center of Health Science Research of the University of Minnesota to develop a proposal.

2. The hospital peer groupings shall be the same.

3. The weighted average inflation guidelines shall not exceed the allowable increase limit established by MDH.

4. MHA will consult with MDH on all policy questions.

5. MHA will develop new summary exhibits consistent with MDH requirements.

6. MHA will require hospitals to submit a narrative pricing policy. (This is required by the rules but was not being done.)

7. MHA will submit all reports, data and review-related materials to MDH by the first of the next month after receipt or completion of review.

8. MHA will notify MDH and the HSAs of all reviews.

9. MHA will inform the HSAs of the rate review outcomes for hospitals in their service areas.

10. MHA shall work with MDH to satisfy all public information requests.[1]

Although the state is legally responsible for policymaking in the system, it should be clear from the conditions listed above that many policy-like decisions are being made within MHA's Rate Review Program. The state maintains that such delegation of policymaking authority is deliberate and necessary for maintaining the essential "cooperative spirit" of the existing rate review system. In particular, the Department argues that, despite various procedural problems, the program is currently working because hospitals are involved and committed to the program. The Department maintains that, if the state were to be more aggressive in regulating MHA's review program, the relationship could quickly become adversarial, and the state does not have statutory authority to deal with such a situation. Moral persuasion is said to be the only real instrument available for containing hospital costs, and a cooperative, nonadversarial environment is thought to be crucial to the success of a moral persuasion approach. The state is also reluctant to deny MHA's annual reapplication as a rate review organization or to see MHA itself withdraw from rate review; the Department of Health does

[1]MDH completed its review and recertified MHA just one week prior to the site visit. Consequently, most of these changes had not been implemented at that time.

not at present have the stand-by resources and staff to actually conduct the review program. Although the Department would receive the same fees from hospitals as MHA currently uses in financing its rate review program, those funds would go directly into the general fund without necessarily any change in the appropriation for Rate Review within the Department.

It is difficult to reliably assess where policymaking authority actually resides within MHA. In principle, the Rate Review Panels have ultimate authority. However, there are six panels which meet only once a month, and then only for review purposes. Furthermore, any panel can refer "technical" questions (which often also involve questions of policy) to MHA's Advisory Subcommittee. The recommendations of the Advisory Subcommittee, as approved by MHA's Board and Finance Committee, are invariably accepted by the panels without ever being submitted to an actual vote.

As seen above, MHA has also exercised substantial policymaking responsibility in the procedural area (e.g., designing exhibits or forms). MHA staff usually take the initiative in this area but generally review its recommendations with the Rate Review Panels and/or the Advisory Subcommittee and solicit their support. In addition, the individual financial analysts who are assigned responsibility for reviewing each hospital have broad discretion in specifying the intensity and range of each review.

MHA leadership sees problems in the present organizational arrangement and had not planned to continue it. The Chairman of MHA's Finance Committee, a hospital administrator, noted a concern about the potential for antitrust, price-fixing litigation under the present arrangement. (As will be described in a subsequent section, MHA has once been threatened with such litigation.) Whereas the statute explicitly exempts any voluntary rate review program from state antitrust litigation, it does not and cannot exempt it from federal antitrust litigation. MHA counsel has explored the issue with the regional office of the Federal Trade Commission (FTC), but that office declined to give an opinion and advised MHA not to pursue the issue. The Finance Committee Chairman also noted that the existing program has a serious credibility problem. He affirms the efficacy of the program but recognizes that the independence and objectivity of MHA as an industry watchdog may seem questionable to the public. Other MHA representatives have mentioned the same problem. It was likewise noted by many, including the Chairman of the Advisory Subcommittee, that the present arrangement is awkward, since MHA is now its own adversary and, consequently, some member hospitals have become disenchanted with MHA. In particular, the MHA staff is both friend and adversary; they have sometimes aided

hospitals in preparation for review and then either criticized or not supported them in the review. MHA had wanted greater leeway in giving assistance to its members when actually appearing before the Rate Review Panels.

For all of these reasons, MHA was going forward with plans to incorporate the Rate Review Program as a separate legal organization and split it off from MHA.[1] The new organization was to be called the Rating Authority of Minnesota, Inc. (RAMI). The concept was first approved by the MHA Board in August, 1977. The new organization was to have five MHA-nominated hospital directors and an additional six nonhospital or nonprovider directors, who would also be appointed by the Hospital Association in the first year. Afterwards any replacements would be appointed directly by the RAMI Board of Directors. MHA had hoped that RAMI could be formally approved by its hospital membership and activated by September 30, 1979. However, a minority of hospitals were resisting the change, and MHA recently changed its position, voting not to go forward with the plan.

Timing of the Review Process

Each hospital must submit its budget request for review sixty or fewer days prior to the end of its fiscal year. In principle, the entire review process is to be completed in the sixty-day interval following submission of the rate revenue and expense report because rates cannot be increased until the end of that period. However, in the first year of review, it was not possible to maintain that schedule, and many reviews were not completed until several months after a hospital had begun its fiscal year. Review is now being conducted more closely on schedule. MHA's "ideal" timetable for each task in the review process is shown in Exhibit I. However, because they have not been able to maintain a rigid schedule, the individual review tasks are completed as circumstances and resources permit.

The Review Process

The hospital review process is not strictly a rate review process, although it is known as such because it is the central activity of the Minnesota Hospital Rate Review System. The rates per se are not the main criteria for review. Inasmuch as the subsequent year's budget is the focus of review and rates are set consistent with the approved budget, it is perhaps more correctly called a budget review process. On the other hand, the

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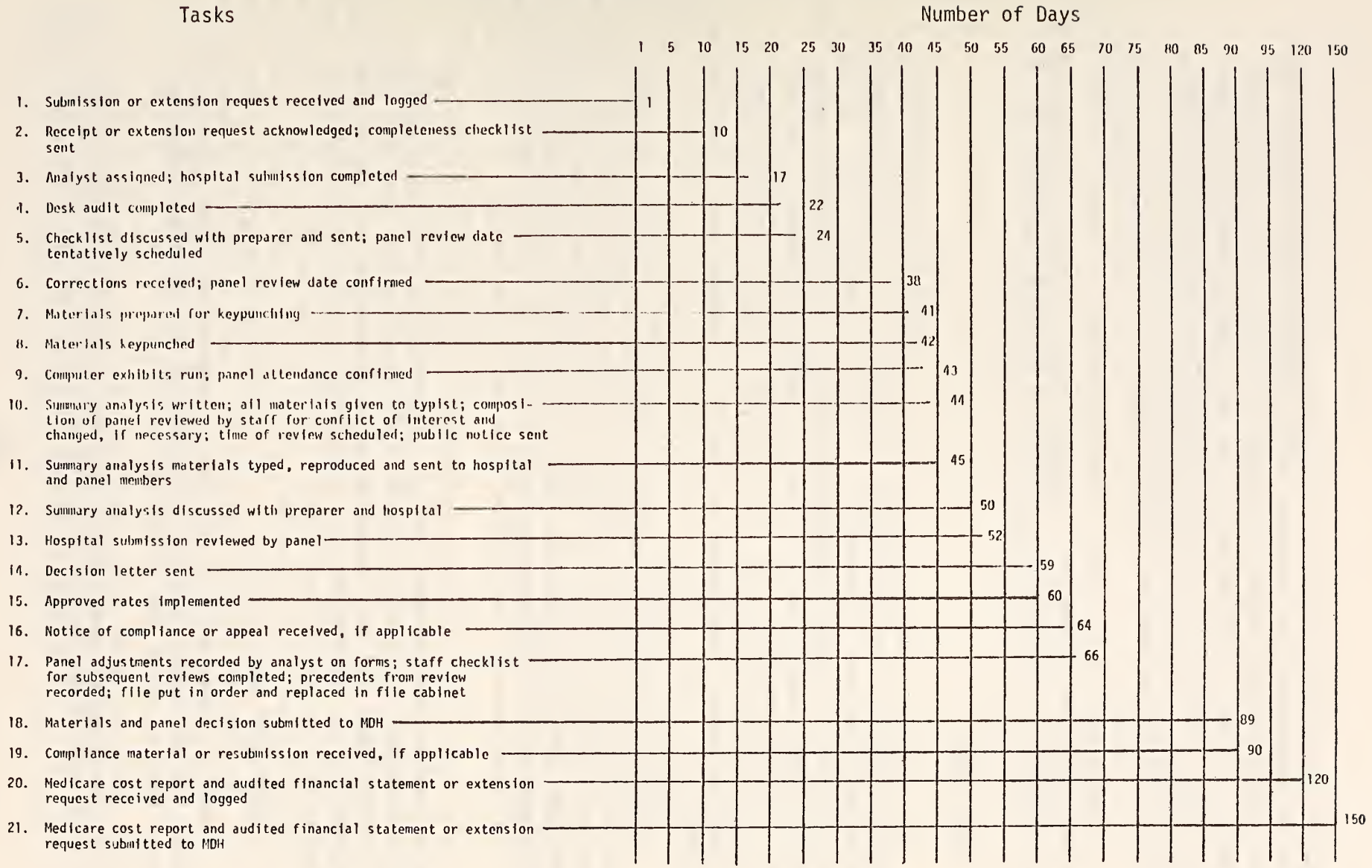
[1]The founder of MHA's rate review program had recommended establishing a separate corporation in 1975 but could not generate enough support for the idea within MHA at that time.

EXHIBIT I

MHA RATE REVIEW PROCESS: TIMETABLE OF TASKS


Tasks
Number of Days
1 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 120 150
1. Submission or extension request received and logged
2. Receipt or extension request acknowledged; completeness checklist sent
3. Analyst assigned; hospital submission completed
4. Desk audit completed
5. Checklist discussed with preparer and sent; panel review date tentatively scheduled
6. Corrections received; panel review date confirmed
7. Materials prepared for keypunching
8. Materials keypunched
9. Computer exhibits run; panel attendance confirmed
10. Summary analysis written; all materials given to typist; composition of panel reviewed by staff for conflict of interest and changed, if necessary; time of review scheduled; public notice sent
11. Summary analysis materials typed, reproduced and sent to hospital and panel members
12. Summary analysis discussed with preparer and hospital
13. Hospital submission reviewed by panel
14. Decision letter sent
15. Approved rates implemented
16. Notice of compliance or appeal received, if applicable
17. Panel adjustments recorded by analyst on forms; staff checklist for subsequent reviews completed; precedents from review recorded; file put in order and replaced in file cabinet
18. Materials and panel decision submitted to MDH
19. Compliance material or resubmission received, if applicable
20. Medicare cost report and audited financial statement or extension request received and logged
21. Medicare cost report and audited financial statement or extension request submitted to MDH
1
10
17
22
24
38
41
42
43
44
45
50
52
59
60
64
66
89
90
120
150

requested percentage increase in revenue per adjusted admission is a key factor in determining the intensity of the budget review.[1] However, the actual budget review focuses on the level of hospital cost per adjusted admission and the rate of change in cost per adjusted admission in the budget year. Although the approved percentage increase in the rate is the principal criterion used in gauging hospital performance, the rates of cost and revenue increase per adjusted admission are also noted.

Although MDH has developed its own methodology or process for reviewing hospitals, MDH has implemented it for only one hospital, and MHA has not used it. A summary of the MDH review process can be found in Appendix A. The focus below is on the review process being used by MHA.

Desk Audit

Upon receipt of each hospital's rate request package, the MHA staff assistant checks it for completeness and assigns it to a financial analyst. The analyst first uses a three-page checklist for minimal audit. If major form preparation problems are found, a full audit is conducted. Because of time and staff limitations, even the full audit is strategic. The desk audit has three purposes: (1) to corroborate reported information with last year's projected figures; (2) to verify arithmetic accuracy; and (3) to check for proper presentation of data (i.e., presentation consistent with the rules).

After the desk audit is completed, the financial analyst typically calls the hospital to indicate problem areas and request corrections. The major problems identified in the desk audit often become issues for review unless resolved by the hospital. The larger hospitals, in particular, will sometimes make an improper presentation in order to challenge system policy. In such cases the staff facilitates a meeting of the issue.

Any corrections to the rate revenue and expense report are received and reviewed by the financial analyst. Occasionally, the analyst finds that a hospital has changed other parts of its submission than that for which corrections had been requested. Such changes are not allowed unless the hospital can demonstrate that it had made an error in the original submission.

Summary Analysis

A set of standard format exhibits or analyses is prepared by the MHA analyst for comparative summary of information in the rate revenue and expense report. These are the following:

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[1] It is also the criterion used for determining whether an interim price increase must be approved by the system.

- Hospital and Comparative Cost Data;
- Volume-Adjusted Functional Cost Analysis;
- Salary and Full-Time Equivalent Analysis;
- Analysis of Changes in Drug Volume, Costs, and Revenues;
- Analysis of Changes in Medical Supply Volume, Costs and Revenues;
- Analysis of Working Capital;
- Allowances--Budget Year;
- Uncollectibles;
- Charges to Financial Requirement Ratio; and
- Summary Analysis.

The Hospital and Comparative Cost Data exhibit gives basic statistics--number of acute beds, convalescent and nursing care beds, total acute patient days, and occupancy--for the prior year, current year and budget year (projected), and computes the percentage rates of change. The average length of stay, the costs per adjusted and unadjusted stay, and the costs per adjusted and unadjusted day are also reported. Each hospital is compared to its peer group for these statistics. Hospital variation from the group mean is indicated for each cost-per-stay variable. Finally, the hospital's two-year trend or rate of increase in cost per adjusted stay is compared to the trend for its peer group mean.

The Volume-Adjusted Functional Cost Analysis gives estimates for the current and projected rates of price inflation in fifteen functional cost categories and compares them to the budgeted rates of price increase in the current year and to inflation guidelines for the budget year, respectively.[1] The rates of price or cost increase are calculated as expense divided by an appropriate volume measure--e.g., number of full-time equivalents (FTE) for salary expense and number of prescriptions for drug expense. These data are also used to calculate volume-adjusted price variances in both the current and budget years. The total of unfavorable variances in the current year is noted and may be offset against financial requirements in the

[1]The categories are salary, employee benefits, medical fees, raw foods, drugs, medical supplies, other supplies, utilities, repairs and maintenance, equipment rental, insurance, interest expense, building depreciation, equipment depreciation, and other expense.

budget year. However, this would be done only at the discretion of the reviewing panel.

The Salary and Full-Time Equivalent Analysis determines the average salary per full-time equivalent, the total number of full-time equivalents, and the number of full-time equivalents per occupied bed in the prior year, current year, and budget year. It also calculates the percentage rates of change. Each hospital is also compared to its peer group on these criteria.

The Analysis of Changes in Drug Volume, Costs and Revenues presents information on the number of patient days, drug units, drug costs, and drug revenues in each of the three years. The percentage rates of change in patient days and drug units are computed, as well as the percentage rates of increase in drug costs and revenue due to price change.

The Analysis of Changes in Medical Supply Volume, Costs and Revenues is the same as the drug analysis above except that it analyzes the volume, costs, and revenue of medical supplies instead of drugs.

The Analysis of Working Capital calculates other receivables, inventories, prepaid expenses, accounts payable, and other current liabilities as a percentage of total expense in each of the three years, as well as the rates of change for each. The number of days' charges in total patient receivables is also computed for each year and the effect on working capital requirements of any budgeted change is calculated. Each hospital is also compared to its peer group.

The Allowances Analysis lists the projected distribution of charges by payor for the budget year, calculates the Medicare and Medicaid contractual allowances, and compares these estimates to the hospital estimates.

The Uncollectible Analysis indicates the number of days' charges accumulated as uncollectibles in each of the three years and calculates the rates of change. Uncollectibles are similarly analyzed as a percentage of total revenue.

The Charges to Financial Requirements Ratio analysis merely calculates the percentage rate of increase being requested and computes the percentage increase in patient revenue implied by the volume projections. This analysis also computes the total patient charges in the budget year as a percentage of financial requirements.

The Summary Analysis merely summarizes all these analyses. A copy of the shell format for this is presented as Exhibit 2.

The MHA Analyst reviews the analyses for problems; only those analyses indicating problems are given to the panels. The analyst has considerable flexibility in assessing whether or not each analysis identifies a problem to

EXHIBIT II

Hospital and Comparative Cost Data

A. _____Hospital is an institution with _____ acute licensed beds. It is located in _____, which is _____. There are _____hospitals within ____miles of _____: _____, with ____acute beds; _____, with ____acute beds; and _____, with ____acute beds. The occupancy, based on licensed beds (line 4), has fluctuated, decreased, increased remained steady over the three-year period. In the prior year (PY) it was ____%. It dropped to ____%, rose to ____%, remained at ____% in the current year (CY) and is expected to decrease to ____%, increase to ____%, remain constant at ____% in the budget year (BY).

B. Average length of stay has decreased, increased, fluctuated between the PY and the CY., BY. In the PY it was at ____days, which is ____% below above the group mean. In the CY it decreased, increased to ____days and is expected to decrease to ____days, increase to ____days, remain constant at ____days in the BY.

C. The adjusted cost per stay variance (line 11) for the hospital was $_____ or ____% less, greater than the group mean in the PY. As can be seen on line 6, the adjusted cost per stay decreased,increased ____% from the PY to the CY and is expected to decrease, increase ____% in the BY. Lines 15 and 16 indicate that by the end of the BY, the two-year compounded rate of increase of the adjusted cost per stay will be ____%. This is ____% more less than the projected group mean of ____%. This faster,slower growth rate means that in the BY the cost per stay variance will be $_____ less, greater than the projected group mean.

Volume Adjusted Functional Cost Analysis - Form A

_____ Because this institution is undergoing Rate Review for the first time, those price increases occurring particularly in the BY should be examined for reasonableness. However, cost increases in the CY should also be examined for appropriateness. Of special concern are variances in both the CY and the BY in . Variances in the BY alone are found in . Variances in the CY can be seen in .

_____ Because this institution has undergone Rate Review before, those price increases occurring in both the CY and the BY should be examined for reasonableness. Cost increases in the CY should be scrutinized for adherence to last year's budget and in the BY for similarity to MHA's inflation guidelines. Of special concern are variances in both the CY and the BY in . Variances in the BY alone are found in . Variances in the CY can be seen in .

CY and BY
A.

____ Salaries (line 1)
____ Employee Benefits (line 2)
____ Medical Fees (line 3)
____ Raw Food (line 4)
____ Drugs (line 5)
____ Medical Supplies (line 6)
____ Other Supplies (line 7)
____ Utilities (line 8)
____ Repairs and Maintenance (line 9)
____ Equipment Rental (line 10)
____ Insurance (line 11)
____ Interest Expense (line 12)
____ Building Depreciation (line 13)
____ Equipment Depreciation (line 14)
____ Other Expense (line 15)

BY alone
B.

____ Salaries (line 1)
____ Employee Benefits (line 2)
____ Medical Fees (line 3)
____ Raw Food (line 4)
____ Drugs (line 5)
____ Medical Supplies (line 6)
____ Other Supplies (line 7)
____ Utilities (line 8)
____ Repairs and Maintenance (line 9)
____ Equipment Rental (line 10)
____ Insurance (line 11)
____ Interest Expense (line 12)
____ Building Depreciation (line 13)
____ Equipment Depreciation (line 14)
____ Other Expense (line 15)

CY alone
C.

____ Salaries (line 1)
____ Employee Benefits (line 2)
____ Medical Fees (line 3)
____ Raw Food (line 4)
____ Drugs (line 5)
____ Medical Supplies (line 6)
____ Other Supplies (line 7)
____ Utilities (line 8)
____ Repairs and Maintenance (line 9)
____ Equipment Rental (line 10)
____ Insurance (line 11)
____ Interest Expense (line 12)
____ Building Depreciation (line 13)
____ Equipment Depreciation (line 14)
____ Other Expense (line 15)

Salary and Full Time Equivalent Analysis

Total FTE's decreased increased by ____% in the CY while patient days decreased , increased by ____%. As a result, FTEs per occupied bed increased from ____in the PY to ____in the CY. Average salary per FTE in the CY was $_____above the group mean of $_____, or ____% above the group mean.

Exhibit IV - Analysis of Changes in Drug Volume, Costs, and Revenues

The hospital is showing a ____% decrease, increase in drug costs per unit (line 7) and a ____% decrease, increase in revenue per unit (line 8).

Exhibit V - Analysis of Changes in Medical Supply Volume, Costs and Revenues

The hospital is showing a ____% decrease, increase in medical supply costs per unit (line 7) and a ____% decrease, increase in revenue per unit (line 8).

Exhibit VI - Analysis of Working Capital

The number of net days' charges in net patient receivables decreased, increased from ____days in the PY to ____days in the CY. This is ____days higher than the group mean average of ____days in the CY. In the BY, net days charges is expected to decrease, increase to ____days.

Exhibit VII - Allowances - Budget Year

The hospital's estimate of the Medicare and Medicaid discount is $_____ greater than that calculated by using the gross margin method. The hospital should be prepared to explain the methodology it used in calculating allowances.

Exhibit VIII - Uncollectibles

The hospital's number of days' charges in the accumulated provision has decreased, increased from ____days in the PY to ____days in the BY.

Charges to Financial Requirement Ratio

The hospital is requesting an increase of ____% in charges due to price. This increase will result in $_____ of additional revenue and will set total patient charges equal to ____% of financial requirements. When the change in volume and mix (intensity) is applied to this price increase, an increase of ____% in patient revenue results.

be reviewed. It is largely a question of judgment, since there are no guidelines for making such determinations.

The Summary Analysis, the other analyses to be reviewed, and an agenda listing discussion topics are distributed to the hospital and the designated Rate Review Panel about one week prior to review. Panel members also receive the complete Rate Revenue and Expense Report and the past year's decision letter. The hospital may choose to meet with staff in advance of the panel meeting to review problem areas.

The Panel Review Meeting

The hospitals to be reviewed typically send two to four representatives to the Panel Review, usually including the hospital administrator and financial manager. The head nurse often also attends. Although the meetings are open to the public, outside observers rarely attend.[1]

The MHA financial analyst begins the review by reviewing the topics for discussion. Panel members then have the opportunity to put additional topics on the agenda. The hospital representatives make an opening statement and respond in detail to items on the agenda. The hospitals are encouraged to use printed hand-outs in order to avoid unnecessary questions during their presentation. The panel members then have the opportunity to question the hospital on each agenda item. When the hospital representatives have answered all questions, the panel goes into executive session. Although the hospital representatives can remain and listen to the deliberations, they cannot participate. Finally, the panel votes a specific rate increase, along with any specific conditions (e.g., reduce FTEs) they deem appropriate. The entire review typically takes two-and-a-half to three hours, although some have taken as long as three working days.

Apart from the rules defining financial requirements and the problem areas identified by staff, the panels have no formal guidelines by which to evaluate a hospital's rate request and have virtual autonomy in conducting the review itself.[2] After introducing the agenda, the financial analyst rarely speaks except to elaborate on staff concerns, clarify the rules, or answer a factual question from the panel or the hospital. The MHA Director of Rate Review only appears before Rate Review Panels to make policy presentations. Although the MHA Program Manager always consults with the designated analyst prior to the review session, he usually attends only the

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[1]Until recently, a notice of each meeting was sent to the local newspapers. However, these notices are generally not published. Apart from notifying MDH, there had been no further effort to publicize the meetings. As a result of MDH insistence, MHA is now notifying HSAs and PSROs.

[2]Except for an orientation meeting at the beginning of the voluntary program, there have been no formal training sessions; nor have all the panels met at one time to discuss policy.

larger hospital reviews. However, he discusses program developments with the panel before the review session or during the lunch break.

A letter formally notifying the hospital of the panel's decision is drafted by the financial analyst and sent out a week after the review. The hospital must then give MHA written notice of whether it intends to comply with the decision and set its rates accordingly. To date, only one small hospital has given notice that it would not comply with respect to its approved rates. However, several of the more sizable institutions have indicated that they could not comply with other special conditions. For example, the level of wage increase at the state's University Hospital was unusually high because of state civil service requirements, and a Rate Review Panel refused to approve the level. University Hospital, of course, was powerless to do anything about it. MHA had initially planned to send a letter about the problem to the State Civil Service Commission, the HSA, and the PSRO, but never actually did so.

Financial Requirements

The rules for rate review state that ". . .rates must supply the financial resources necessary to meet the financial requirements [emphasis added] of a hospital." Inasmuch as the rules also define "financial requirements" with considerable specificity, this definition becomes a crucial policy variable, affecting the cost-saving potential of rate review in that it specifies purposes for which reasonable costs must be allowed. As already noted, the definition of financial requirements adopted by the Minnesota Hospital Rate Review System is similar to the one developed by MHA for its earlier rate review program.

The rules include the following as financial requirements:

1. Direct patient care expense;

    a. Salaries, wages, employee fringe benefits, services, supplies, normal maintenance, minor building modification, and applicable taxes;

    b. The monetary value of services provided by religious orders;

2. Interest expense--operating and plant capital needs;

3. Educational program expenses;

    a. ". . .can be directly demonstrated to contribute to the care of patients";

    b. ". . .can be demonstrated to contribute to the preventive health education of the population of areas of patient origin";

4. Research program expenses "due to research programs which relate directly to daily patient care";

5. Bad debt;

6. Fifty percent of Hill-Burton liability--other charity can be financed from depreciation;

7. Government contractual allowances;

8. Cost-justified discounts;

9. Capital needs;

   a. annual straight-line depreciation

   b. price-level adjustment to annual depreciation expense, less interest on the depreciation fund;

   c. approved plant and equipment capital needs in excess of available income;

10. Working capital--the incremental difference between current assets and current liabilities;

11. Auxiliary enterprises--all nondirect patient-related activities should be self-supporting and, if profitable, profits should be used to reduce rates;

12. Other operating income, nonoperating income, and gifts--other income and unrestricted gifts, including board-designated funds, must be used to reduce rates; donor-restricted gifts must be used for their intended purpose and used to offset the associated cost.

A few of the above require explanation. First of all, price-level adjustment on depreciation involves using price indices to adjust for the difference in depreciation at historic and current price levels--i.e., the increase in replacement value. Such explicit price-level adjustment is unusual and is shown as a profit on more traditional income statements. It can be a substantial amount, especially in older hospitals. While the purpose of normal depreciation is to allocate the expense associated with the use of a capital asset over the useful life of the asset, the purpose of price-adjusted depreciation is more nearly to finance the eventual replacement of all plant capital. Whereas the earlier voluntary program had allowed the entire price-level differential, the system now reduces this amount by the amount of annual interest on the depreciation fund. Consequently, according to state estimates, most hospitals still receive

only forty to sixty percent of the actual replacement cost.[1] The state's Director of Rate Review nevertheless believes that the fundamental concept of price-level adjustment is inappropriate given the existence of excess capacity in Minnesota hospitals. He notes that the present price-level depreciation method distributes plant capital funds to all hospitals irrespective of whether or when they need to be replaced. The Director would rather have plant capital monies "targeted" to hospitals with planning-approved capital needs.

The rules also express such an interest:

> The annual increment to the plant capital fund, when projected over the lives of the depreciable assets of the hospital using the current year's experience, should be evaluated with regard to the individual hospital's capital needs in relationship to the appropriate health systems agency's area-wide health plan and the State Health Planning and Development Agency's State Health Plan (p. 23).

The rules further provide that the price-level adjustment may be reduced in proportion to the hospital's excess capacity, as determined by the Rate Review System in consultation with the appropriate Health Systems Agency, Professional Standards Review Organization, and State Health Planning and Development Agency. This provision of the rules will be applied to hospitals' 1980 fiscal rate reviews based upon 1978 actual occupancy data.

The "cost-justified discount" is another unusual feature of the Minnesota system. The following is a key provision of the Rate Review Statute:

> The Commissioner of Health may initiate reviews or investigations. . . to assure all purchasers. . . that rates are set equitably. The Commissioner of Health shall prohibit hospitals from discriminating among insurers in its rates (Statute 144.701).

MDH construes this to mean that although the Rate Review has no authority for regulating Medicare and Medicaid reimbursement, Blue Cross/Blue Shield and commercial insurors must pay the same rates unless any price differentials can be shown to reflect payor-related cost differences--i.e., cost-justified discounts. HMOs and other payors are specifically excluded by statute. The system nevertheless uses the same criteria in commenting on the appropriateness of discounts to the HMOS and other

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[1]MDH recently discovered that MHA has begun allowing the full price-level differential.

purchasers. The newly revised rules give the following as criteria for cost-justified discounts:

- differences in payor admitting requirements;
- differences in payor accounting and audit requirements;
- differences in payor billing procedures;
- time value of money (cash payment and length of time taken to pay); and
- other cost-reducing activities undertaken by specific payors that do not simply and inequitably shift costs from one payor to another.

The definition of cost-justified discounts has caused considerable controversy. In the first year of the mandatory program, the MHA Rate Review Advisory Subcommittee ruled, with MDH approval, that differential bad debt experience was not an acceptable basis for cost-justified discount. It was reasoned that bad debt is a communal or social expense not affected by the policies of individual insurors and that its cost should be borne proportionately by all payors. However, the HMOs and HMO-participating hospitals took issue with that interpretation and threatened litigation, including a charge that MHA was engaging in restraint of trade and was therefore in violation of antitrust legislation. MHA sought affirmation of its overall cost-justification methodology with MDH; however, MDH declined to provide it. MDH was advised by counsel that the rules were not sufficiently precise to support a specific algorithm for this purpose. Thus, MDH and MHA have temporarily conceded the issue, and bad-debt-related discounts are presently allowed. However, the newly revised rules sought to clarify the definition of cost-justified discounts and could conceivably preclude such discounts in the future.

The rules on financial requirements also specify how income from nonpatient sources is to be offset against costs. In principle, all unrestricted funds--including those subsequently restricted by the hospital--must be used to reduce total financial requirements.[1] However, in response to specific inquiries by MHA and several hospitals, MDH recently decided, acting on advice from counsel, that this rule does not include unrestricted funds received prior to the effective date of the system. In addition, Rate Review cannot jeopardize government reimbursement. Inasmuch as Medicare

[1]Under MHA's 1974-1976 voluntary rate review program, unrestricted income, excluding hospital Board of Trustee-designated funds, was applied against financial requirements only to the extent that price-level adjustments and working capital increases were included as financial requirements.

and Medicaid pay the lower of costs and charges, nonpatient income cannot be used to reduce rates below the Medicare reimbursable level. This provision affects most government hospitals, including University Hospital and Hennepin County Hospital--two of the largest hospitals in the state. These two hospitals have substantial unrestricted income from legislative allotment and the county tax base, respectively, and Rate Review is effectively restrained from making any negative comments on their rates. Rate Review can and has commented unfavorably on their costs, however, and the newly revised rules provide explicit authority to do so.

The rules also require "loss carryforward" and "offset of gains" from the prior year, after adjusting the approved rates for volume variance. That is, after adjusting for volume, an unbudgeted loss vis-a-vis the financial requirements figure approved for the prior year was to be carried forward and included as a financial requirement in the budget year. Likewise, a "gain"--patient revenue in excess of the approved, volume-adjusted financial requirements figure--was to be offset against financial requirements in the budget year.[1] This has not been done. Instead, the actual operating losses and profits (or gains) under the more generous "financial requirements" definition of actual costs have been carried forward and offset, but it is not clear that the rules can be reasonably construed as supporting this alternative.

Inflation Factor Projection

MHA determines the budget-year inflation guidelines by polling various hospital representatives and suppliers about the probable rates of price increase and averaging projections across respondents in each cost category--a delphi-type approach. For example, the health labor management firm that represents almost all Minnesota hospitals in collective bargaining had been queried with respect to the expected level of wage settlements in the forthcoming year. However, the labor management firm now refuses to make such forecasts, and MHA labor cost guidelines are based upon recent labor settlements, local CPI trends, and the Presidential Wage Guidelines.

MDH is not satisfied with this procedure and prepares its own price inflation guidelines using national price index projections developed by Data Resources Inc. (DRI) and adjusted by MDH for historic regional variations from the national pattern. For example, the wholesale price indices for farm products and processed foods and feeds are averaged to yield the inflation guideline for the raw foods category. MHA maintains that nationwide price indices are not appropriate for projecting inflation in the State of Minnesota and that the price indices being used are also not

[1]The newly revised rules indicate additional criteria for adjusting the approved financial requirements figure--e.g., ". . .unanticipated losses resulting from overestimates of reasonable volume and/or revenue, and/or underestimates of the reasonable costs of services delivered. . . ."

appropriate for the hospital industry. In general, the MDH projections have been somewhat less than allowed for in the guidelines adopted by MHA.

The Peer Grouping Procedure

In its approach to peer grouping, MDH first partitions hospitals into three groups: major teaching, other urban, and rural. Cluster analysis is then used to group hospitals on the following characteristics within each category:

- a service index;
- surgical procedures per admission;
- percentage Medicare utilization;
- percentage Medicaid utilization;
- county per capita income (rural hospitals only); and
- numbers of active physician staff by specialty (nonteaching, urban hospitals only).

This procedure generates fourteen peer groups, but one of the peer groups has been subdivided into three additional subgroups--children's hospitals, hospitals specializing in alcoholic and psychiatric care, and more standard referral-type hospitals--because of the apparent differences in hospital function. At present, the peer groups are used for comparison of hospital financial aggregates in the analysis of Hospital and Comparative Cost Data. They are also used in the Salary and Full-Time Equivalent Analysis and in the Analysis of Working Capital. MHA is further planning to incorporate peer group screens into the natural cost analysis.

Data

The rules require that each hospital annually submit a report of rate revenue and expense information to the Minnesota Hospital Rate Review System sixty or fewer days prior to the end of its fiscal year. No rates can be changed until sixty or more days have elapsed from the date of filing. This report must include financial and statistical information for three years: the hospital's last full and audited accounting period; the full accounting period during which the hospital is filing, including at least six months of actual information; and projections for the hospital's subsequent accounting period--i.e., the prior year, the current year, and the budget year. The rules indicate that the following must be included as part of this report:

Statistical information for the Rate Revenue and Expense report, including:

1. The number of inpatient days for the hospital and each appropriate service center;

2. The number of admissions for the hospital and for each appropriate service center;

3. The average number of FTE employees during each accounting period for the hospital and for each of its service centers (an employee or any combination of employees who are reimbursed by the hospital for 2080 hours of employment per year is a FTE employee);

4. The number of beds (licensed), the number (the statistical mean) of beds physically present, and the number (the statistical mean) of beds actually staffed and set up for the hospital and for each appropriate service center;

5. The number of outpatient clinic visits for the hospital;

6. The number of emergency visits for the hospital; and

7. The number of units of service provided by each of the hospital's other service centers. (The hospital shall select the statistic that best measures the level of activity for a particular function or service center and that, in addition, is compiled on a routine basis by the hospital to serve as the appropriate unit of service for each of its service centers.)

Financial information for the Rate Revenue and Expense report, including:

1. An interim financial statement of the hospital, which shall include an interim balance sheet and an interim income and expense statement for the current year only. The balance sheet and income and expense statement shall conform to the requirements of 7 MCAR S. 1.474 A.1. and 7 MCAR S. 1.474 A.2. This financial statement shall contain a minimum of six months of actual information for the current year;

2. A statement of expenses for the hospital and for each of its service centers and a statement according to natural classifications of expenses as provided by 7 MCAR S. 1.474 A.2.a.(6);

3. A statement detailing the accounting method used to allocate expenses from among the nonrevenue centers to revenue centers, which shall detail compliance with the offsets to costs and allocation of costs specified by the bases for judging stated by 7 MCAR S. 1.487 A;

4. A statement of total direct and indirect costs for the hospital and for each of its service centers before and after the allocation of expenses;

5. A statement of the accounts receivable by type of purchaser of services and a statement of the average aggregate number of days' charges outstanding at the end of each period;

6. A statement of changes in financial position showing the source and application of all funds for each period; and

7. A statement of the capital budget of the hospital.

The report of Rate Revenue and Expense shall also contain the following information:

1. The pricing policy of the hospital, which incorporates the overall pricing policy and financial objectives of the institution. This will be supplemented by a statement of budgeted increases in charges, revenue, and aggregate rates for the budget-year, including these items:

   (a) Date(s) on which charges, revenue, and aggregate rates will be adjusted;

   (b) For each date, the resulting aggregate dollar amount and weighted average percent of increase in budget-year aggregate rates and gross charges for each revenue center;

   (c) For each date, the resulting aggregate dollar and weighted average percent of increase in budget-year total hospital revenues; and

(d) For each date, the resulting aggregate dollar and weighted average percentage of increase in budget-year total hospital revenues.

2. Attestation by the hospital's governing authority or its designee that the rates are set equitably and without discrimination among the insurors;

3. In the case of a hospital with expanded facilities, a copy of the hospital's report used to obtain a Certificate of Need for the expanded facility, which projects the patient and service activity levels of the expanded facility for its first five years of operation (pp. 12-14).

This information is currently being elicited by MHA on the following forms or schedules:

(1) Financial Requirements--Total Institution and Hospital

Purpose: To summarize financial requirements in standardized classifications and to compare patient charges to financial requirements for both the entire institution and the hospital only.

(2) Comparison of Patient Charges by Revenue Center

Purpose: To summarize and compare patient charges by department for the three-year operating period.

(3) Expense Analysis

(a) Revenue Centers--Direct Costs

(b) Non-Revenue-Producing Centers--Direct Costs

(c) Total Allocated Costs

Purpose: To provide a three-year comparison of the institution's operating expenses by cost center. Direct expenses, indirect expenses, and total expenses after allocation are reported. Costs per unit of service are calculated all three years for these same expense classifications.

(4) Salary and Full-Time Equivalent (FTE) Analysis

Purpose: To provide a comparison of salaries and full-time equivalents (FTEs) by department for the three-year reporting period. FTEs per 1000 units of service are also presented in order to analyze staff additions in relationship to volume.

(5) Statistical Summary

Purpose: To summarize departmental and natural cost statistics for the three-year reporting period.

(6) Hospital Depreciation Fund Analysis

Purpose: To show the activity of the hospital depreciation fund and to determine that the proper funding of historical cost and price-level depreciation has been done.

(7) Restricted and Board-Designated Fund Analysis

Purpose: To show the activity of the hospital's restricted and board-designated funds.

(8) Price-Level Depreciation Adjustment

(a) Buildings and Building Equipment

(b) Movable Equipment

Purpose: To calculate the price-level depreciation adjustment for buildings, building equipment and movable equipment.

(9) Working Capital Requirement

(a) Allowances and Uncollectible Accounts

Purpose: To calculate working capital requirements and to summarize allowances and uncollectible accounts.

(b) Net Receivables

Purpose: To calculate net receivables and net days' charges in accounts receivable by payor.

(c) Hospital Medicare/Medicaid Allowances

Purpose: To estimate Medicare and Medicaid allowances. This method is suggested: the institution may choose other methods, but any other method should consider the costs-to-charges relationship and should be supported by working papers.

(10) Other Operating and Nonoperating Revenue

Purpose: To summarize other operating revenue and nonoperating revenue.

(11) Capital Budget

Purpose: To detail capital expenditures for the three-year reporting period and one additional year.

(12) New Service Incremental Cost Analysis

Purpose: To detail the additional costs and statistics associated with added services.

(13) Supplemental Detail Schedules

Purpose: To provide added departmental detail and to reclassify this detail according to the departments shown on the main forms.

(14) Current Financial Statement

Purpose: To include balance sheet, statement of revenue and expenses, and statement of changes in financial position of restricted and unrestricted funds.

(15) Operating Budget

(16) Schedule of Present and Proposed Rates

(17) Certificate of Need Report

(18) Detailed Schedules of Revenue and Expense for Auxiliary Enterprises

(19) Dollar Amount of Hill-Burton Liability

(20) Pricing Policy

Each hospital must also file a report of annual financial information no later than 120 days after the end of its fiscal year. This report must include the following: (1) an audited balance sheet detailing the assets, liabilities and net worth of the hospital; (2) an audited statement of income and expenses; (3) an unaudited copy of the hospital's Medicare cost report; (4) attestation by the hospital's board that the contents of the reports are true; and (5) attestation that the balance sheet and income statement have been audited. The audited Medicare cost report must also be submitted as soon as it becomes available.

If at any time a hospital wishes to increase its average rate beyond that stated in its current rate revenue and expense report, and if the cumulative rate of increase for the year exceeds an allowable increase limit established by MDH, the hospital must also file an interim increase report sixty days prior to the effective date of rate change. An interim increase report must indicate any changes in financial and statistical information for the budget year and include a statement of the rationale for a rate increase.

The system requires neither uniform reporting nor accounting. In particular, reporting is uniform only to the extent that hospitals begin with the same forms and receive a recommended account distribution index for consistent classification of natural cost categories. The hospitals may substitute financial information in any format maintained by the hospital, as long as it also submits a reconciliation between its submission and the recommended one. Both MDH and MHA perceive the lack of reporting uniformity and consistent definitions as being a problem. However, both noted that greater uniformity could entail greater expense to the hospitals than justified by the potential benefits. In addition, MDH is reluctant to commit state resources to developmental efforts until the ongoing work in California and at the federal level can be completed and reviewed for its appropriateness to Minnesota.[1]

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[1]In conducting a 1978 economic impact study for the Metropolitan Health Board (the health systems agency), Price Waterhouse & Co. noted the following problem with the data furnished by Rate Review:

> Certain hospitals do not provide the same detailed information generally supplied by the hospital community. For example, St. Joseph's Hospital does not differentiate between Medical/Surgical, Pediatrics or Obstetrics, but instead reports "General Hospital." Because of this, determination of the change in costs which might occur due to changes in patient days must be done on a very "average" basis. Other institutions also do not provide specific information, such as North Memorial, which does not differentiate their psychiatric unit, and United Memorial [sic], which does not report Pediatrics (p. 10).(Continued on the following page.)

The Rate Revenue and Expense Reports were apparently filed on schedule in the first year of review under the statute; however, some 120 hospitals did not file audited financial statements and Medicare cost reports on schedule in that year. In its 1977 annual report, MDH noted a concern that MHA might actually have been in receipt of these reports but had not filed them with MDH as required (p. 6). However, the problem has apparently been resolved. Some hospitals have also submitted less information than requested by the Rate Revenue and Expense Report because of "loopholes" in the rules. The loopholes were removed by revision of the rules.

Smaller hospitals required substantial staff assistance in preparing the Rate Revenue and Expense Report during the first year. Rate Review staff found that a disproportionate amount of their time was being spent helping these hospitals, especially in view of the more limited cost savings potential in small hospitals.[1] Furthermore, the reporting requirements were relatively more burdensome to these smaller hospitals. Consequently, the rules have now been amended to substantially reduce the reporting requirements of the smallest hospitals, which account for less than fifteen percent of aggregate hospital costs in Minnesota. This includes eighty-one percent of all Minnesota hospitals. Detailed reporting by cost center is no longer required, and a five (5) percent "profitability factor" is acknowledged as a financial requirement in lieu of calculated price-level depreciation and working capital requirements.

Since legislated review of hospital rates began in mid-1977, four different sets of forms have been used to collect the required data from hospitals: the MHA voluntary program form sets were used initially; a form set developed under the auspices of MDH was tried for a period of time and rejected as unworkable; MHA redesigned its own form set to comply with requirements of MDH; and finally, an abbreviated form set has now been adopted for smaller hospitals, congruent with the changed rules for small hospital reporting. Such multiplicity of form sets in such a short period of time has caused confusion among panel members. However, MDH maintains that panels should not be reviewing form sets, but only the summary analyses.

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[1](continued)

A report compiled by the West Metro Hospital Trustees Council entitled "Recommended Changes in the West Metropolitan Health Care System" also recognized the problem when it recommended that state policy is needed to better coordinate PSRO, Certificate of Need and rate review including standardization of all data (page 55).

[1]The 120 smaller hospitals in Minnesota together account for only fifteen percent of the state's total hospital expenditures.

Litigation, Appeals and Compliance

To date, the Rate Review System has never entered into litigation, although that has been threatened on several occasions.

Any hospital can appeal the decision of its Rate Review Panel, but to date few have. The Appeals Panel is simply a different Rate Review Panel, of which there are six. The rules provide for more formal appeal in a contested case hearing before the state, but only for hospitals being reviewed by the state.

The system does not have authority to enforce compliance with the decisions of Rate Review. Nevertheless, it is possible to monitor compliance for informational reasons--e.g., to evaluate program effectiveness. In any event, neither MHA nor MDH is currently monitoring "compliance" with respect to the recommended rates. However, beginning with the 1980 budget year, compliance checks will become part of the loss/gain carry-forward determination. Even so, MHA maintains on the basis of hospitals' notification of intent to comply that compliance is near complete, but such claims should be viewed skeptically until supported by more objective evidence. On the other hand, MHA is now monitoring compliance with respect to specific conditions imposed by a Rate Review Panel (e.g., increase productivity). In addition, the Volume-Adjusted Functional Cost Analysis (refer to the section on content and process) can be said to monitor compliance with respect to the rates of price increase by natural expense category.

Although it is not part of the formal audit routine, MHA is currently watching whether or not the depreciation claimed in prior budget submittals has actually been funded, as required by the rules. They have found problems in a few rural hospitals and have reported them to the reviewing panels.

Program Cost

MHA's budget for 1978, exclusive of loss carry-forward, was about $240,000. MDH's budgeting allotment is about $120,000. However, MDH does not pay rent and certain other overhead expenses. The MHA Director of Rate Review has estimated that the total program cost, including the cost to hospitals of complying with reporting requirements, was about $800,000 in 1978.

Recent Developmental Efforts

A variety of developmental projects have already been noted in discussion of other topics. Most recently, MDH has conducted an econometric cost analysis of the relationship between average cost per adjusted admission

and the peer grouping variables used by the state--variables that are thought to measure differences in resource requirements. Whereas a large proportion of the variation in cost (seventy-eight percent) is explained by the grouping variables, the analysis also raises considerable doubt about the equity of peer grouping. In particular, the high- and low-cost outliers from regression analysis were not always the same as the ones from peer group comparison. Some high-cost hospitals from peer group comparison were found to have reasonable costs, given the differences between them and other hospitals in the same peer group, and some apparently low-cost hospitals were found to be unreasonably expensive.

MDH is also continuing an earlier study on the financial position of hospitals in Minnesota, which is hoped to isolate the impact of rate review on hospitals' financial condition.

As already noted, MDH and MHA developmental efforts have been substantially independent of one another. The developmental studies conducted to date by MHA have not been documented. In 1979, MHA is planning two major developmental efforts: a study of cost-justified discounts and revision of the exhibits and cost screens. MHA has also made a proposal to HCFA for development and implementation of an experimental diagnostic-related reimbursement program. MHA is additionally proposing to become the data "broker" for all regulatory-related reporting by Minnesota hospitals. That is, all data required by Rate Review, the PSROs, the HSAs and perhaps other regulatory programs would be reported directly to MHA, and MHA would, in turn, disseminate the information to the various regulatory programs.

INTERACTIONS

This section considers the relationships and interactions between the Rate Review System and various health and other interested parties.

Health Systems Agencies

Five of the seven Health System Agencies within the state, including the two multistate HSAs, have received designation. However, only four of them--Metropolitan, Central, Southwest and Northeast--have had any interaction with Rate Review. They are using Rate Review data for reviewing Certificate of Need (CON) applications, and they participate in rule making.

The Metropolitan HSA--the Metropolitan Health Board--is unusually mature as an organization, having evolved originally from a Hill-Burton planning agency and having enjoyed continuity of leadership throughout. It has also been unusually successful in promoting and accommodating the participatory approach to hospital planning. In 1977, a long-standing civic study group

in Minneapolis/St. Paul--the Citizens' League--prepared a report on hospital costs. It compared the Minneapolis/St. Paul area to the demographically similar Seattle-Tacoma area and found that the hospital utilization rate was two-thirds again as much in Minneapolis and St. Paul as that in Seattle-Tacoma. The League recommended that the Metro Health Board and the hospitals jointly effect a reduction of 1,500 to 3,000 beds. This recommendation was subsequently reaffirmed by the Health Board's Viable Hospital Task Force. The task force report also proposed that the hospital industry develop a plan responding to the recommendations. Two hospital trustee groups, East and West Metro, were organized for this purpose.

The East Metro Trustees recommended temporary "banking" for a limited number of excess hospital beds. However, the West Metro Trustees recommended a substantial bed reduction and the elimination of services not meeting the guidelines in the Health Systems Plan. In mid-1979 the Metro Health Board was scheduled to release a much awaited report naming specific hospitals in which certain specialized services (e.g., pediatrics, open heart and radiation therapy) should be phased out and identifying certain hospitals that risk closure. It remains to be seen whether or not Rate Review will cooperate in implementing such recommendations.

The SHPDA is said to be tied up in politics and has not given much support to the HSAs. However, it has participated in rulemaking for Rate Review.

PSROs

The PSRO in the Minneapolis/St. Paul area--the Foundation for Health Care Evaluation--appears to have been unusually successful. It began implementing control in 1975, and all thirty-six metro-area hospitals were included by 1977. About seven hospitals have been placed on probation at one time or another. Patient days per 1,000 eligible Medicare beneficiaries in the service area went down 10.3 percent in 1977. Total patient days in medical/surgical were down 100,000 in 1977, and a similar reduction is projected for 1978. These reductions were partly offset by an increase in hospitalization for chemical dependency and psychiatric services. The Foundation is releasing information to MDH on case-mix-adjusted length of stay by hospital.

Third-Party Payors

Blue Cross/Blue Shield has been an active participant in the system; it makes five or more employees available as MHA Rate Review Panel members and participates in all rule-making activities at MDH. Prior to the Rate Review legislation, Blue Cross/Blue Shield (BC/BS) had paid the lesser of costs and charges in hospitals having 2,500 or more BC/BS days, and ninety-seven percent of charges in hospitals having fewer than 2,500 BC/BS days.

As already noted, the statute prohibited hospitals from giving unjustified contractual allowances to nonfederal payors and thus precluded Blue Cross/Blue Shield's continuing to reimburse on these terms. Blue Cross/Blue Shield subsequently negotiated contracts in which it agreed to pay 100 percent of Rate Review-approved charges. This has potential for becoming a "back door" approach to rate setting inasmuch as hospitals are restricted from charging different rates to other, nonfederal payors. However, until recently, BC/BS made no attempt to monitor actual compliance with Rate Review recommendations and had even been unaware that one hospital openly declared its intent not to comply. It is doubtful whether BC/BS could exercise much restraint in any event; their contracts would no doubt be cancelled if they really sought to pay only the Rate Review-approved amounts. Although Blue Cross/Blue Shield is eligible for the same cost-justified discounts (see section on financial requirements) as have been given to HMOs, BC/BS has declined to claim them. Perhaps their payment practices do not justify a discount, yet BC/BS has been demanding a study to establish criteria for cost-justified discounts.

The Health Insurance Association of America (HIAA) representative serves as a Rate Review Panel member. However, the national HIAA office has been critical of the Minnesota program for three reasons: the inability of an industry to regulate itself; the lack of documentation; and a concern about the loyalties of the MDH Director of Rate Review, also the former director of MHA's voluntary program. The state representative privately avowed that the system is more effective than HIAA believes.

The HMOs have participated in the system only to the extent of making personnel available as panel members. In fact, as was noted in discussion of HMO discounts, they have partly thwarted the system's movement toward nondiscrimination in the rates. Nevertheless, the spokesman for one HMO allowed that Rate Review had been a factor in reducing their hospital discounts. He expressed concern that Rate Review is making hospitals less responsive to market forces.

The Legislature

The legislature appears to have a continuing interest in the Rate Review System but has no regular liaison with it. Several persons noted that, with the recent election of a Republican governor and an even split in the formerly DFL-dominated House, there is little chance of passing legislation in the near future that would put more "teeth" into the system. If anything, it could go in the opposite direction. One hospital representative alluded to the possibility of legislation that would remove the state from the system altogether and that, with the formerly planned incorporation of

Rate Review as an entity separate from MHA, it could be more persuasively argued that MDH's functions are superfluous and redundant.

The state legislature has just recently enacted an amendment to the Rate Review statute. It exempts from review hospitals that anticipate moderate rate increases.

> The commissioner of health shall periodically establish a percentage figure for an acceptable increase in hospital gross acute care charges. Any hospital which files with the commissioner an abbreviated projected operating statement and which represents in this statement that it anticipates a percentage increase in annual gross acute care charges less than the figure established by the commissioner shall be exempt from the review of projected annual revenues and expenses. . . .If any exempted hospital exceeds the figure established by the commissioner, it shall promptly file a rate review request. . . .

The amendment became effective on August 1, 1979. It was neither supported nor opposed by MDH, but MHA testified against it.

Another bill (1302) affecting Rate Review is still before the legislature at this time. It would require posting of average total hospital charges for common hospital cases or diagnoses, and instructs the Commissioner of Health to seek exemption from any federally mandated hospital rate regulation program. The bill has passed in the Senate and seems to be favorably received in the House.

Hospital Unions

The hospital industry in Minnesota is heavily unionized, with the Minnesota Nurses Association and Local 113 setting the pace. However, the labor relations climate is said to be "enlightened" and cooperative.

The contracts for almost all metropolitan and many other hospitals in the state are negotiated through Health Manpower Management Inc. (HMMI), a private corporation created by the hospitals. The HMMI spokesman reported that Rate Review decisions have not entered into labor arbitration and that hospitals rarely make the argument that they have only so much to spend. In addition, he noted that labor settlements to date have not surpassed the the Rate Review figure. However, a "chicken and egg" analogy was suggested, since MHA relies upon HMMI for its forecast of the increase in labor costs. HMMI does not plan to furnish such forecasts in the future because of a concern that the information will be released and become the floor for

collective bargaining. Although the Nurses Association did examine hospital budget submittals prior to their recent negotiations, the information was apparently not used in arbitration.[1]

Most hospital labor contracts are written for three years at a time and typically are "front-loaded"--e.g., eight percent in the first year, seven percent in the second and six percent in the third. All labor contracts currently include a long-term binding arbitration clause. Until voided by a 1974 amendment to the National Labor Relations Act, the Charitable Hospitals Act dating back to the 1940s had provided for mandatory arbitration and had worked well for twenty-five years. Both management and labor petitioned the National Labor Relations Board to cede authority to the state, but the Board refused to do so.

Medicaid

Minnesota Medicaid reimburses hospitals on a cost retrospective basis similar to Medicare's and has had no appreciable interaction with the Rate Review System. However, Medicaid is now planning, under legislative mandate, a demonstration project wherein twelve hospitals would consent to have their rates set prospectively on the basis of Rate Review recommendations. An HEW waiver for this purpose has been requested.

Certificate of Need

The Minnesota Certificate of Need (CON) program was adopted in 1971 and rules were promulgated in 1973. A Certificate was originally required for total capital expenditures in excess of $50,000. Since 1975, the threshold has been capital expenditures in excess of $100,000 or any project expenditure for new services in excess of $50,000. To date, the Commissioner of Health has remanded only two CON applications for hospitals and has just recently denied one.

Rate Review at MDH comments informally on CON applications, but these comments are said not to be crucial to the outcome. The CON program has no interaction with Rate Review within the Hospital Association.

PRELIMINARY ASSESSMENT

It is perhaps premature to pass judgment on the Minnesota Rate Review System; the system is only two years old, but more importantly, it had been on the verge of a major structural change. The voluntary rate review program at MHA was to be incorporated independent of the Hospital Association. Although it was conceivable that this new organization would also be

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[1]They settled for 7.3 percent as the average rate of increase.

hospital controlled, it at least had the promise of having a more constructive and cooperative relationship with MDH and less potential for conflict of interest. The present semiadversarial relationship between MDH and MHA has been a serious liability to the system, usurping resources and resulting in redundancy (e.g., developmental work). It is unclear what will happen now that MHA has decided not to go forward with the change.

The system is also laboring under a number of other significant limitations. First of all, it does not have rate-setting authority and thus cannot enforce compliance with Rate Review recommendations. This may or may not be undesirable in the long run, but it most assuredly creates procedural obstacles in the short run. The efficacy of the system rests substantially on its perceived "moral authority" and the collective acquiescence of hospitals. Even if hospitals are sufficiently public spirited to make a voluntary program work, they must nevertheless be persuaded of the program's merit and the merit of any proposed changes in it. That is, a voluntary program might reasonably be expected to take a longer time in maturing and proving itself effective.

The rather generous definition of financial requirements--namely, the inclusion of substantial price-level adjustment on depreciation--is also a serious constraint on the system's short-run performance. By definition, any broadening of the base for allowable costs must lead to an increase in reimbursement and therefore cost to the consumer. In fact, there is some circumstantial evidence that this is happening. During 1978, the Rate Review System approved 9.42 percent as the average rate of change in revenue per adjusted admission, compared to only 6.81 percent for the average rate of change in average cost per adjusted admission. (The reader is cautioned that actual experience may have been very different.) That is, the projected rate of increase in revenue or reimbursement was almost forty percent higher than the projected rate of increase in current costs. As long as the price level depreciation is funded, as required, any such short-run increase in reimbursement should be offset by a longer-run reduction as the funded depreciation is used to finance new capital acquisition. On the other hand, if it is not funded, the net effect could be increased cost.

The lack of uniformity in accounting and reporting is perceived by some--e.g., MDH, metro HSA, metro PSRO and state HIAA--to be a major structural problem of the system. MHA argues that the benefits of greater uniformity would not exceed its costs. Although it is perhaps an empirical issue, MHA's view does not represent the general consensus outside of Minnesota.

The review process in Minnesota is relatively unstructured compared with the approaches found in most other states under study. Apart from the rules defining financial requirements and the problem areas identified by staff, the Rate Review Panels have no formal guidelines or direction in conducting review. Given widespread hospital concern about the equity of so-called mechanistic approaches to rate setting, it will be important to evaluate the efficacy of this less structured alternative.

Although review of the process has not been completed, two Panel Review meetings were observed. The panels tended to focus on minor technical questions--e.g., whether or not the operating loss on a gift shop could be counted as a financial requirement. The peer group comparisons were quickly dismissed or discounted when differences between the hospital being reviewed and other hospitals in the peer group were noted.[1]

Rate Review staff note that hospital sophistication and preparedness are major factors influencing the outcome of review. In addition, it was said that panel composition is important and that certain provider representatives tend to be parochial, although most are not. Ambiguity and arbitrariness were also cited as general problems. In addition, one hospital representative noted that Rate Review staff did not have adequate experience and resources to put them on an equal footing with the hospitals. At present, Rate Review staff do not make any recommendations to the Rate Review panels, apart from identifying areas of concern. However, a panel will sometimes ask staff to express an opinion about the reasonability of the hospital's justification. The summary exhibits and analyses are much less sophisticated than the state of the art in this area, and the absence of departmental cost analyses is conspicuous. However, such refinements may not be possible without more uniform reporting.

The above limitations aside, <u>all</u> on-site respondents insisted that the Minnesota Rate Review System has been successful. However, it was more often said that the results were due to the greater "cost consciousness" and budgetary sophistication promoted by the review process than to the rigor of review itself. Whereas it is easy to be cynical about the extent of hospital involvement in the Minnesota system, many nonhospital respondents emphasized the importance of hospital cooperation and commitment to Rate Review. In conclusion, Minnesota offers an excellent context for evaluating the efficacy of a less structured, self-regulated approach to hospital cost control.

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[1]A recent study by MDH supports the generally skeptical view that panels have taken of the peer groupings.

APPENDIX A

Excerpt from "A Summary Description of the Process Used by The Minnesota Department of Health"

. . .Reasonableness criteria include the degree to which:

1. Rates are similar to the average of the aggregate rates then in effect for other hospitals in a peer group;

2. Excessive hospital costs that may be associated with duplication of services should be discouraged;

3. Increases in hospital rates should be more closely linked to increases in the prices of goods and services in the general economy.[1]

In general terms, the review process operationalizes each of the program objectives by the use of sets of financial incentives and budgeting guidelines:

1. Efficient production of services is encouraged by comparing each hospital's costs with its peer group for a prior period which has been fully audited. This comparison emphasizes variable cost considerations, but not to the total exclusion of a consideration of efficient use of capital which is expressed by fixed costs. This particular phase of the review should encourage the development and maintenance of "good" internal budget and control systems.

2. The review process addresses the issue of excessive costs due to duplication by not allowing the costs (both operating and capital) of projects requiring a Certificate of Need to be included in projected expense prior to the acquisition of a Certificate of Need and by detecting inefficiencies in prior period costs resulting from the underutilization of assets. The latter review component emphasizes fixed costs. The phase-out of underutilized beds is also encouraged through the use of an "excess capacity adjustment" which can reduce otherwise reasonable revenue requirements.

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[1]These objectives seem to be common to the majority of state rate review programs. See Katherine Bauer, "Hospital Rate Setting--This Way to Salvation?" The Milbank Memorial Fund Quarterly 55 (1), Winter 1977.

3. Linking rates of increase in hospital costs (rates) to projected increases in the general economy is achieved by establishing inflation guidelines which are then to be followed by hospitals when budgets are prepared.

To be specific, the rate review and screening procedure utilized by the Minnesota Department of Health is a two-track system comprised of a base year and budget year analysis. The base year is the year for which a projected budget is submitted for review minus two, e.g., if a hospital is submitting a budget for its fiscal 1978 the base year would be fiscal 1976. Intensive analysis begins with the prior year because all expenses and statistics are actual rather than estimated (in total or in part) and financial statements have been finalized.

A hospital's base year costs (accounting expenses) are compared to the average (median) costs for its peer group. The comparisons are ordered in the following sequence and serve as screens or filters that separate those institutions that may have excessive costs from those that do not. . . :

1. Average total cost per adjusted admission--hospital cost versus its peer group median;

2. Average total cost per adjusted admission for each category of natural expense, e.g., salaries, drugs, medical supplies, etc.--hospital cost versus its peer group median;

3. Average cost per adjusted admission for:

   a. Daily services, i.e., nursing service (before and after allocation of indirect costs), and

   b. Ancillary services (before and after allocation of indirect costs),

   c. Non-revenue producing centers--hospital cost versus the 60th percentile for its peer group for each of the three areas and for each "large" hospital[1] where cost exceeds the 60th percentile; and

[1]A large hospital is a member of the set of hospitals that constitute 85 to 90 percent of total expenditures made by non-state, non-federal hospitals in the state during any calendar year.

4. Average cost per unit of service and productivity standards for departments within the area or areas exceeding the 60th percentile--hospital versus peer group averages.

All costs in excess of peer group norms, i.e., those that exceed the 60th percentile for daily services, ancillary services, or non-revenue producing centers, may be determined to be unreasonable and carried forward to the budget year as an offset to a hospital's revenue requirements. This is done under the premise that unreasonable expenditure patterns should not be constrained into the future. The budget year analysis is comprised of a comparison of the hospital's growth in costs over the current year projected into the budget year. (For example, if the budget year is 1978, then the current year would be 1977.) Hospitals may have their costs judged unreasonable in instances where growth in average cost per adjusted admission exceeds guidelines for increases established by the Department. These guidelines, reflecting changes in both the prices of goods and services purchased by hospitals and in "mix and intensity," are applied to actual and projected costs over the current and budget years. The same could be true for budgeted increases in the unit cost of items comprising the natural expense categories that exceed budget year inflation guidelines developed by the Department. Those costs determined unreasonable would be offset to the hospital's revenue requirements for the budget year.

Finally, the increase in projected average revenue per adjusted admission is compared to the allowable increase limit, a factor (developed by the Department) that considers the increase in the prices of goods and services and increases in mix and intensity of the services delivered to patients to determine if the projected rate of change in revenue is supported by the projected rate of change in cost. Unsupported increases in revenue may be determined to be unreasonable.

Each hospital has an opportunity to justify any amounts in excess of peer group norms or the Department inflation guidelines prior to a final determination of reasonableness by the Commissioner of Health. Pursuant to 7MCAR S.1.487 E. the burden of proof of reasonableness rests with the hospital.

APPENDIX B

PERSONS WHO HAVE PROVIDED INFORMATION USED IN THIS CASE STUDY

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Technical Advisory Review Board
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